

PREPARING AFRICAN AMERICAN CHURCHES TO DEVELOP HIV/AIDS
RELATED MINISTRIES: AN INTERVENTION MODEL FOR TRANSFORMING
AFRICAN AMERICAN FAITH COMMUNITIES

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A FINAL PROJECT SUBMITTED TO
THE DOCTORAL STUDIES COMMITTEE
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF DOCTOR OF MINISTRY

UNITED THEOLOGICAL SEMINARY
DAYTON, OHIO
December, 2009

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ABSTRACT

PREPARING AFRICAN AMERICAN CHURCHES TO DEVELOP HIV/AIDS RELATED MINISTRIES: AN INTERVENTION MODEL FOR TRANSFORMING AFRICAN AMERICAN FAITH COMMUNITIES

by

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This case study examines the need to establish HIV/AIDS-related ministries in selected African American churches within Dayton, Ohio. This case study consists of interviews, questionnaires, testing, education, and pre- and post-surveys. The researcher employed over the course of 12 weeks, a model to examine the challenges African American churches are facing with this issue. Research results found during this intervention in implementing the model will help to prepare the selected churches to assist in addressing this devastating disease. Of the 40,000 new HIV infections in the United States each year, an estimated 65% occur among African Americans.

ACKNOWLEDGEMENTS

This ministry project has represented a massive undertaking for me on a very complex, yet compelling issue that faces a whole culture of people. To my project team which was comprised of dedicated, selfless individuals who endeavor to make a difference in the lives of the least of them, my eternal gratitude belongs to you. My passion for this ministry project has been born out of personal tragedy. The loss of two cousins to the AIDS epidemic. I come to this project with extreme prejudice, which is the explanation for my passion. However, the passion of others drove me to complete this work.

Chief among those has been my wife, Alicia. Without her love and devotion to my passion, there is no way that this project could have a successful conclusion. In addition, my children, Larry, Aaron, and Roxanne have inspired me to be all that I can be. My daughter-in-law, Tiffany, an African American woman who sets a marvelous example for her peers who are an endangered species, and my grandchildren, Adonijah and Anaiah, who drive me to continue to make a difference in the world they must grow up in. My prayer for them all is that they are inspired to do greater works than I could.

To the good people of Mt. Olive Baptist Church in Dayton, Ohio: I am overwhelmed when I think of this ministry project and how so many of you have responded to help impact the lives of so many persons and their families, persons with HIV/AIDS and the difference you made in their lives by the way you treated them. My

heart is overjoyed with love and respect for you. You are taking God at His word and making a difference in the lives of His created beings by loving them through yourselves. For trusting your Pastor, embracing this vision to serve, transform and make a difference, not only in others' lives, but to help transform a community, has been simply amazing. Your love and support has been overwhelming. Thank you.

PREFACE

The researcher has, for several years, wrestled with the impact that the HIV/AIDS virus was having on the African American culture. While not fully sure of what course of action was necessary, it was quite clear that some course of action was critical. After much prayer and soul-searching, the author was lead to the institution that has provided many critical responses to critical questions in the African American culture. Those answers now, as they were then, are in the African American church. It is through this venue that the researcher intends to provide some solutions to this rapid growing epidemic of HIV/AIDS in the African American community.

The selected participants in this case study are five (5) African American churches in the Dayton, Ohio area. The researcher has requested the support of persons infected and affected by the HIV/AIDS virus, and many collaborative community stakeholders who are committed to the dream of the eradication of this dreadful disease. Their experience and collective expertise will provide the kind of grassroots intelligence that is necessary for any project of this nature to be successful. Germane to this project is a critical examination of the relationships and perceptions of many of these infected and affected individuals with the African American church.

The researcher will engage many not-for-profit agencies and state and federal government entities to provide the necessary assistance, guidance, and data to help drive this project to conclusion. Specifically, the researcher has contacted Wright State

University, Public Health Montgomery County, Dayton Baptist Ministerial Alliance, Interdenominational Ministerial Alliance, and the Center for Disease Control (CDC).

DEDICATION

This ministry research project is dedicated to my late beloved mother, Mrs. Edna M. Williams. For her courage and strength and for the example that she set before all of her children of how to live Godly. She taught me how to persevere through difficult times and to hold on to the God she trained me to know. A woman of great vision who knew how to make much out of a little, to make sure that her children were loved. It is because of her that I am involved in ministry, and I owe her a tremendous debt, that shall never be repaid, for helping to mold my life. I will serve the people of God with the same dedication that I received from my mother.

To the persons infected and affected with HIV/AIDS, please know that you do not struggle alone. There are many dedicated persons working on your behalf and I dedicate this effort to you. I find that one of my mother's old sayings is applicable here, "hold on, help is on the way."

EPIGRAPH

The religion of Jesus makes the love-ethic central. This is no ordinary achievement. It seems clear that Jesus started out with the simple teaching concerning love embodied in the timeless words of Israel: “Hear, O Israel: The Lord our God is one Lord: and thou shalt love the Lord thy God with all thy heart, and with all thy soul, and with all thy might,” and “thy neighbor as thyself.” Once the neighbor is defined, then one’s moral obligation is clear. In a memorable story, Jesus defined the neighbor by telling of the Good Samaritan. With sure artistry and great power, he depicted what happens when a man responds directly to human need across the barriers of class, race, and condition. Every man is potentially every other man’s neighbor. Neighborliness is nonpartial; it is qualitative. A man must love his neighbor directly, clearly, permitting no barriers between.¹

¹ Howard Thurman, *Jesus and the Disinherited* (Boston, MA: Beacon Press, 1976), 89.

INTRODUCTION

The purpose of this ministry project is to create an awareness of the state of the African American church and have it respond to the pandemic of HIV/AIDS within and outside its walls. Given the nature of this pandemic and that according to The Center for Disease Control, that in just one year from now (2010), over 100 million people will have the HIV virus, the fact that this disease is not a focal point for most African American Churches is astounding. The Center for Disease Control also points out that in the African American community; eight out of every ten people have contact with some person in their lives who has some affiliation with a church. The author intends, through written documentation of biblical, historical, and theological foundation, to provide examples of why the church is so prominent in the African American community, as well as why the African American church cannot, and must not, remain silent on the issue of the HIV/AIDS virus.

As the new millennium continues to unfold, AIDS—Acquired Immunodeficiency Syndrome, is referred to as the number one public health issue of our time, a disease for which there is presently neither vaccine, nor cure. This deadly disease affects our families, our loved ones, and our society; its existence is a constant topic of conversation. In fact, HIV and AIDS have become household acronyms. In communities across America, students as young as junior high school age can recite, with ease, these six

letters and words for which they stand. Media broadcasts regularly inform us of new educational initiatives, medical breakthroughs, and social services geared towards HIV/AIDS. Yet, for all the recent advances in care, treatment, and education, HIV/AIDS continues to wreak havoc in African American communities. While new HIV infections are declining among whites, African Americans are dying in greater numbers. Seemingly, the rate at which AIDS is spreading outpaces the rate at which African American communities are responding to it.

Current statistics are alarming. Surpassing heart disease and homicide, AIDS is now the leading cause of death among African American women and men ages 25-44. Of the 40,000 new HIV infections in the U.S. each year, an estimated 65% occur among African Americans. African American women are 16 times more likely to contract AIDS than white women. The disproportionate impact is glaring: African Americans comprise roughly 13% of the U.S. population, yet account for nearly 50% of all AIDS cases. In addition, while the death rate from AIDS is declining in the general population, it continues to escalate among African Americans. To put it more graphically, HIV/AIDS threatens the very existence of African Americans in this country. The harsh reality of the situation exacerbated only by a high incidence of substance abuse. If African Americans as a people are to stem the rising tide of HIV infection, more segments of the community must become actively involved in HIV prevention. Chief among the segments is the African American church, a stalwart of faith, education, and community activism for more than 200 years.

The context of this ministry is a medium-size African American church that is looking to influence not only its members and community on the issues of HIV/AIDS and

other preventable infections, but also the larger associational setting of which this church is a member. The larger associational body can provide access to seventy churches and thousands of members. These African American churches must be challenged to have inclusive ministries that deal with the myriad of problems associated with HIV/AIDS illnesses. Within the context of the large associational setting of seventy churches, less than five speak on the issues of HIV/AIDS and none of them have ministries that address this issue that is ravaging the African American community and its churches. The goals of this project are: (1) established wellness ministries that included HIV/AIDS and other infectious diseases, (2) to challenge the lack of inclusiveness in the household of faith, (3) to provide a model that can be replicated throughout the African American church at large.

The benefits of such ministries and education will be more people doing the mission of the church, more members in the churches, greater diversity of fellowship, more compassion for fellow human beings, and a strong, more relevant church to the community it resides in.

In Chapter One, the author describes the context of ministry and the historical foundation from which this ministry project evolves. The author discusses the formative personal relationships that motivated the author to deal with the complex issues that the author finds in his current ministry context. A brief analysis of this context is provided.

In Chapter Two, the author speaks to the absence of HIV/AIDS ministries in many African American churches and the need for social activism. The author also addresses the need for training of clergy and the necessity of the African American church to be fully mobilized in this fight against HIV/AIDS.

In Chapter Three, the author identifies sources of interpretation emanating from within the African American culture, as well as beliefs and worship. African American theologians contribute to the theoretical foundational framework. Theological ramifications from the lay perspective are included. Historical cultural significance from the contextual governing bodies are examined.

Chapter Four, Research Methodology Results of the Final Project, describes the methodology and project design used in developing the ministry project. The researcher explains the research methodology and how it relates to reducing the number of HIV infections.

Chapter Five explains the Field Experience. The researcher describes the activities, experiences, and knowledge gained while conducting the field research. This chapter also provides education on testing groups.

In chapter Six, Reflection, Summary and Conclusion, the researcher provides reflections on the research project, the researcher's vision for this ministry project, lessons learned, and experiences with other clergy.

The last section of the project is the Bibliography; the researcher provides a listing of the resources used in the formation and development of this ministry project. These sources were from numerous areas of government, professionals in the health care arena, social organizations, scholars, and people filled with a passion to make a difference in the lives of otherwise marginalized folk.

Contrary to popular belief, unmarried and even married persons in the church are having sex in non-monogamous relationships. Education on HIV/AIDS and contributing issues such as the down-low phenomenon could drastically affect the rate of HIV/AIDS

infection in the fastest growing population of HIV infections (African American heterosexual women). Since African American women are the majority of most of the African American Churches, and they represent the fastest growing population of HIV infection, it would seem to a logical step to make the African American church a prominent front-runner in the fight against HIV/AIDS.

CHAPTER ONE

MINISTRY FOCUS

And the king will answer them, “Truly I tell you, just as you did it to one of the least of these who are members of my family, you did it to me.” Matt. 25:40, New Revised Standard Version (NRSV)¹

Formative Personal Relationships

The author is an African American male in a traditional African American Baptist Church. This means that the author is writing from a position of privilege and power in the African American church. This position, while viewed as some to be a blessing, for the author it comes with a double-edged sword, a blessing and a curse.

The author was born in Washington, D. C. on August 9, 1954, in the old Freeman’s Hospital. The questions of being born free resonate with spirit. I later found out that everyone would enjoy my freedom as I would. Racism and sexism has always been a part of the author’s world, the extent has varied through the years. While racism was prominent, the sexism was more subtle because much of it came from within the author’s own culture.

¹ Unless otherwise noted, all Scripture references are taken from the New Revised Standard Version.

As far back as the author can remember of his early childhood, Christ had always been a part of the author's life. The author raised in a two-parent home where Christ was the center of his mother's world. Since the author's mother, like most African American women, had the primary responsibility of raising the children, Christ became the center of the author's world also. The author spent a lot of time in church during the week as well as the weekend. Being very comfortable with church going early in the author's life, at about the age of nine the author received Jesus as His Lord and Savior.

The author's conversion was different than most of the people that he knew. He did not feel any different after baptism as opposed to before baptism. The author was somewhat afraid having seen people come out of the water jumping and shouting, but the author did not feel the same sense of euphoria that others had seemed to experience. In retrospect, the author later learned that like Howard Thurman, his baptism was a gradual conversion.²

The author was trained as a child by his father not to show much emotion. The author's father was a man who never showed emotion or affection and who believed that real men did not engage in that kind of behavior. He worked hard and played equally as hard. The author never once observed his father attend a church service. The impact of that would later influence the author's life. The author's father was not one who would be considered to be called a Christian at that time. Conversely, his mother's lifestyle was one that one would have called Christian and would influence how the author viewed women for a long time to come. The author's mother was always putting the kids first, however the author's dad made sure that the family had a place to stay and something to

² Howard Thurman, *With Head and Heart* (New York: Harvest Book, 1979)

eat. While unable to specify his behavior at that time, the author would later come to understand that his father shared many misogynist viewpoints.

Church was a very stable environment for the author most of his life. It was a safe haven in the midst of dangerous streets and a forgettable environment. Church was that one place where the author was totally accepted, given responsibility, and that place where someone always had time for him. The author has very fond memories of spending a lot of time in church. Most of the author's friends were other church kids with a few exceptions among neighborhood kids. The vast majority of the neighborhood kids never went to church and made fun of the author and his siblings for attending.

These years were critical in the formation of the author's life. While the author and his siblings were going to church and celebrating Jesus, many peers were not. These were lean years. The author and his family were going to church and struggling to get by, while those who were not going seemed to prosper. The author for the first time in his life began to question the value of worshipping God. However, it would not be the last time. Further rattling his faith, the author for the first time in his life witnessed the physical abuse of his mother by his father. After trying, but being unsuccessful at rescuing his mother from his father, the author remembers praying to God that night and having the feeling that God was not listening.

During this time in the author's life, there was a strong feeling of ineptitude by the author for being unable to rescue his mother from his father and a desire to have God answer his prayer immediately. When God did answer the author's prayer immediately, the author made a decision at that time to fulfill his childhood dream to become a police officer. While this was a noble profession, the author's motives were not well intended,

for his sole purposes were revenge and retribution. Little did the author know that what he intended for evil, God intended for good. Many years later the author would be forced to revisit the idea of why he became a police officer.

That summer, while visiting an aunt in Trenton, New Jersey, the author experienced racism for the first time. While playing with a little white boy in the neighborhood where his aunt lived, he was called a nigger. While the author was unclear as to the meaning of the term, his aunt knew and explained the meaning to the author. After a heated exchange with the white kid, the author recalls asking God questions that night about the world and the people that live in it. In addition, the author recalls that it did not appear as if God was listening to his prayers.

Over the next several years of the author's life, the struggle with whether or not God was listening intensified. The author's question, "where is God?" persisted. He had been raised to believe that if one obeys God, good things would happen. He flirted with other religions and eventually left the church of his youth and young adult life.

The author was still reading his Bible, but things were not as clear he had thought they were, before he was forced to confront the things, he had been taught. He found himself in a state of faith versus reasoning. His faith was challenged by what he was experiencing. That childhood dream of becoming a police officer was now a reality. One of the author's first acts after receiving his service revolver was to threaten his father, that if he ever abused his mother again, that he would be arrested. Furthermore, he told his father that if he saw him with a gun, it must be registered or he would arrest his father.

As the author began his career as a police officer he found out that it was not as exciting as advertised. What the author thought, as do many persons, was that police

work was all about chasing bad guys and getting involved in shoot-outs. What he found out was that ninety-eight percent of police work is taking reports and patrolling. Only two percent is filled with the exciting things that the author had seen on television. It was while the author was experiencing some of the report writing task that he first encountered HIV/AIDS.

When the AIDS virus first surfaced in the United States, there was a great deal of paranoia associated with it. Not many persons were quite sure of how to handle persons infected with the virus. Ignorance was then, and continues to be, a major part of the paranoia that exists. Stigma associated with the virus was rampant, violence increased against those persons believed to be the carriers of the virus, especially those persons who were gay, white males. As the assaults increased, so did the need for police intervention. The author vividly recalls responding to local hospitals to interview assault victims and those persons thought to be infected with the HIV virus were kept in quarantined rooms. The author remembers the big rubber gloves and jump suits that he and other police officers would use when dealing with persons who were thought to be infected with the HIV virus.

As the years rolled by, the author began to become cynical about those persons who were contracting the HIV virus. The more time went by, the more cynical he became. This process did not change for the author until God intervened by allowing two of the author's first cousins to be stricken with the HIV virus. These illnesses gave the author a new perspective on those who contracted the HIV virus. It was as if God was saying to the author, "how does it feel when those who are being abused and mistreated are your loved ones and not some anonymous names and faces?"

This is where the author's moral odyssey begins. Over the next few years of young adult life, the author and everything he had believed until now came to that ultimate showdown in life that all seem to face, "who is God?" As time passed and events unfolded, the author found himself in a dilemma. The girl he was dating got pregnant and the author was faced with a multiple dilemma: abortion or delivery? What the author did not know at that time was that this decision would change his life forever.

Her name was [REDACTED] and she entered the world through extreme adversity. Her mother's water broke at five and a half months and she was in labor for two and a half days because the doctors were fearful that the baby's heart has not developed enough to allow her to live. Like most people the author had known in his life when they found themselves in trouble, they turned to God. In spite of his questions about God, the author turned to the people of God and the only God he had truly ever known for help. His mother began to pray, my brother began to pray, the author began to pray, and this time the author heard from God.

[REDACTED], is born weighing 5 pounds and 14 ounces marked a significant shift in the author's life. This miraculous event made him reevaluate his thoughts toward God. What he once believed God to be capable of would never be the same again. He still did have concrete directions from God; but there was a stirring in his spirit that would not let him rest. Now that he had a child, who was born with sickle-cell disease, the author was given pause to re-think how other parents may have felt when their children became HIV-positive. However, before the author could grasp what has happened, he lost his two cousins to AIDS-related complications. These events had a profound effect on the

author's understanding of how he viewed God. It was at this point that the author relocated to the state of Ohio.

Work Experience in Ministry Service

After moving to Dayton, the author began work in Christian ministry when he became a youth advisor at Shiloh Baptist church in Dayton, Ohio. The author's primary responsibilities were to create Christian focus activities involving the male population of the church. In addition to classes on becoming a responsible man, the author created a Christian basketball league with nine other churches. The Christian basketball league was truly the high point of this assignment. This basketball league was unconventional in the sense that the requirements included mandatory attendance at Sunday school the week prior to every game. In addition, when a player committed a foul, they went to the scorer's table to quote a scripture. No scripture given could be repeated twice and this encouraged the players to study their Bibles.

After receiving encouragement from the Senior Pastor, Reverend Doctor Henry L. Parker, the author enrolled in the Christian Lay Education Program at Payne Theological Seminary in 1995 to enhance and broaden his understanding of spiritual formation from more diverse sources of information. During the author's matriculation from this program, he encountered a commencement speaker who would challenge him in ways he had never known. That speaker was Dr. Cornell West. The author had never looked at Christianity the same since that memorable night.

The following year the author began to teach Sunday school and was primarily responsible for lesson preparation and administration for a young adult class. It was during this time of ministry that God used the author in the teaching arena to make scripture come alive and become relevant to many of the issues facing young adult males and females that were not being addressed, mainly because of a traditional perspectives held by the church. This was also a shift from the author's experiences of how the church had dealt with pertinent issues, but the author felt compelled by God to forge ahead and break new ground. Little did he know that this would be the beginning of a philosophy of doing ministry that would carry him into many un-chartered waters.

Subsequently he began teaching Bible study and it was not long before that stirring in the author's spirit began to persist as if to say "there is more work yet to be done." The author's primary responsibility was preparing practical lessons from the Bible, along with the everyday concerns of the members of the author's class. The author's practical approach to teaching and applying the scriptures soon landed him in trouble with the senior pastor. However, this trouble did not deter the him from dealing with serious subject matter brought forth by many of his students, subject matter such as HIV/AIDS, homosexuality, and abuse to name a few. These issues were not dealt with in the traditional setting and the author was now being challenged to do something different within a traditional backdrop. The author decided to trust God and accept the challenge.

During this period, the author acknowledged a calling from God to preach the gospel. After several months of preparation he was examined by a council of elders appointed by the senior pastor and after an initial sermon and a readiness examination, the author was granted a license to preach the gospel. He again was challenged by God to

preach sermons that were geared toward the least of them and those persons who were downtrodden, marginalized, and disenfranchised by society. These types of messages did not win friends, but they challenged the hearers of the word of God to become more than just hearers but doers also. The author could not shake the feeling of losing two cousins to AIDS- related complications and having a daughter born with an incurable disease. A feeling that I could have and somehow should have done more, but I did not.

The author was later appointed to the position of Director of Christian education. He was primarily responsible for education within the church, teachers meeting, and securing curriculum. The continuous stirring in the author's spirit to do more and become better prepared, landed him in seminary. After this long turbulent period in the author's life, he now found himself in seminary coming to grips with his own issues about the existence of God and related to his own misogynistic viewpoints that he was unaware existed.

What seemed to be an amazing transformation to the author was the process that God started in him during his years as a young child. The process would challenge the author, to not only do, but also say the unthinkable in many religious settings. During his final year of seminary, he was called to pastor a traditional African American Baptist church that was over 100 years-old. God not only called the author to pastor, but to be an outspoken critic of misogynistic behavior in traditional settings like the African American Baptist Church and also to spearhead movements in non-traditional areas like speaking out against HIV/AIDS and other infectious diseases. God had instructed the author to not only speak truth to power with regard to these critical issues, but to do

something to shift the paradigm of inactivity to activity and address critical issues in ministry that continue to plague African American communities.

The primary issue that continued to come to the forefront for the author was the reoccurring issue of HIV/AIDS, and the nightmare of the author's cousins who died from the virus. The author had experienced and participated in the stigma, shame, and violence of persons infected with the HIV virus. He also had first hand knowledge of the education and compassion needed to overcome some of the many obstacles associated with persons infected with the HIV virus.

Current Ministry Context

Mt. Olive Missionary Baptist Church was without a pastor for over two years prior to the author's arrival. There were a variety of preachers during this period, all with an eye toward becoming the next pastor. The church is located in an area that is ripe for ministry, within one hundred yards of public housing, a notorious drug corner, crack dealers, and crack houses. In spite of this fertile ground there were no outreach ministries going on in the church, except a food pantry that had been in operation for over forty years. This church had also split twice, with many members following the two displaced pastors.

In spite of this, the author recognized that this was the ministry context that God had placed him in to begin the work of ministering to those persons most in need—the marginalized, disenfranchised persons on the fringes of society. The author also recognized that this would be a formidable challenge given the fact that this was an older

populated church not prone to progressive ministry. Ministering to the aforementioned persons was not a part of the forte of this church.

The author believed firmly in his spirit that God placed him in this church to help shift the paradigm of the traditional thinking of African American churches. The majority of the African American churches the author had experienced in the state of Ohio are traditional, non-forward thinking churches that did not address non-traditional issues affecting African Americans. He was not asking where God was any longer, he was accepting the challenges God was giving him and waiting for God to deliver. One of the first ministries the author engaged in was that of health care. This health care ministry included persons infected and affected by the HIV virus.

By the time author was called to Mt. Olive Baptist church as their new pastor, he had spent several years working with the HIV/AIDS populations in the state of Ohio. This exposure in working with persons infected and affected with HIV/AIDS made for a smooth transition into ministry work with this population. As the author began to solicit those persons from the congregation who were willing to work with such a ministry, he discovered that only one congregant had any previous knowledge of working with persons from HIV/AIDS population. Out of a congregation of about seventy people, only one had any such knowledge.

He clearly recognizes now why his encounter with the Holy Spirit, his two cousins who died from AIDS-related diseases and the birth of his daughter were such powerful experiences for him now. Truly, God was preparing him for a work that would become a central theme in ministry. The author believes that God's infinite wisdom, touched the lives of persons close to the author with HIV/AIDS and other diseases to give

him the compassion that would be necessary to deal effectively with persons infected and affected by many of life's situations requiring more of the usual African American church response. If ever there were a situation that called for an unusual response, that situation is the response of the African American church to the pandemic of HIV/AIDS in the African American community.

To meet the needs of this challenge that has been thrust upon the African American church is what the author believes is his catalyst to move forward and do effective ministry across the board in African American communities. The author is firmly convinced that with the aid of the Holy Spirit, the African American church can be the church of which it is said that they made were receive the challenge from God to do something about this disease and they did it.

One of the author's biggest achievements in the arena of HIV/AIDS thus far has been his work on the creation of a consumer advisory group that is self-named Citizens against Death (CAD), a name developed to express a desire not to tolerate HIV/AIDS-related deaths without doing everything possible to prevent them. This group is comprised of several persons who are HIV-positive or living with AIDS. They advise the author on a regular basis of all of the applicable details, trends, education, medications, and treatment available to persons living HIV/AIDS; as well as issues pertaining to housing, discrimination, job loss, or any other pertinent social issue. God has allowed the author into and around social services for over twenty-five years to make sure that he has been thoroughly prepared for this moment in time.

The author's own experience with his two cousins who were HIV-positive and later died from complications of AIDS has also given him the additional capacity to build relationships with persons from the HIV community.

The trauma of dealing with persons with HIV/AIDS requires additional skills other than those required for working with persons with some socially acceptable health issues. The author is painfully aware of how his family members were treated because of their HIV/AIDS illnesses including how other family members ostracized them and spoke about them away from their presence. There is also the never-ending battle with the expensive medications that without assistance are impossible for many infected persons.

Most of all, the unwillingness and lack of support from other family members, that seemed to hurt worse than the lack of support from strangers.

The author therefore speaks with firsthand knowledge of how the impact of an infected family member has upon the entire family. A person's stance on the matter is of no importance. The impact crosses family lines. Some family members think persons infected got what they deserve, while others are more compassionate in their response to the infected persons. Regardless of how family members feel, the impact on the persons infected with the disease is a difficult one.

While the author cannot speak from the position of one infected, he can speak about what he witnessed with others who have been impacted by the disease. From the hospital rooms to the jail cells and points in between, the author has seen the devastation of this debilitating disease and the havoc it has wreaked on numerous families. It is

especially devastating to watch a healthy human waste away to a mere fragment of what they once were at the hand this disease.

The author believes that people speak from their own social location and those are the positions where they see and understand God for whom and what God is in their lives. Because of this, the author feels inadequate sharing other people's stories, but recognizes that they have stories that must be told if the people of God hope to transform our congregations into service in this arena. The burden of separation from loved ones at a critical time in one's life is not the plan God has for those God loves. The African American church must learn to attract, train, and serve those most in need; especially those persons who have had in many respects society turn their backs on them. This must not continue, particularly because the last measure of hope for many African Americans is the African American church.

Analysis of Ministry Context

The context for this ministry project is the Mt. Olive Baptist Missionary church located at 502 Pontiac Street in Dayton, Ohio. The author will look at the historical context of this and other selected African American churches from their formation until present day. The author's intent is to describe what this and many African American churches have or have not been doing specifically in the area of addressing the needs of those persons affected by and infected with HIV/AIDS. The author believes that the location of many of these African American churches make them accountable to the communities in which they are located. Therefore, the author will also examine the

surrounding community of these African American churches. The intent is to provide as much awareness of the demographics and provide a vivid snapshot of the situation to help the readers of this document conceptualize the landscape.

Finally, the author will share some reflective personal insights from his own experiences in dealing with the African American churches, other professionals in the HIV/AIDS arena, focus groups, and congregants. These reflections will provide a better understanding of this much-needed ministry project, its origins, and objectives. The author is praying for a successful ministry project, as many in the underserved arena of HIV/AIDS ministry are counting on us. The author will begin with the context and developmental foundation of the ministry project.

Context Dynamics and Foundational Development

Mt. Olive Baptist Missionary church, founded in 1902, emerged from its obscure and meager beginnings to become one of Dayton's most powerful and prestigious churches. It is located on the west-side of Dayton, Ohio. Dayton's west side is not unlike many urban settings, frequently described by outsiders as a place where many people dare not venture.

There are many African American churches located on the west side of Dayton, several public schools, and two public housing complexes within a few miles of Mt. Olive Baptist church. There are few businesses in the area and the church sits next to a scrap iron company. It is an understatement to call the area depressed. Many houses are boarded-up or have been demolished. Even the corner store, a fixture in many African

American communities, although now most are operated by non-African Americans, is gone! The city of Dayton zoning board has little or no interest in the area and it shows. When the author engaged the Mayor of Dayton about concerns in the area, her response, however polite, was geared toward the church giving up many of the lots it owns around the church to expand the scrap iron company's business, a tax-paying entity and not a non-profit. With the area around the church in decline and decay, this has prompted many of the older church members to cry for a new church, out and away from this fertile ministry ground. This is a view the author does not share which has led to more than a few discussions and some tense moments in the formation of this project.

However, through the years things have drastically changed at Mt. Olive Baptist church. After being led by one pastor for over fifty years, the last two decades have been marred by corruption; three pastors were voted out of the church; the longest tenured being three years and the shortest less than one year. The church has split twice, reduced the size of the congregation from over six hundred members to less than seventy when the author arrived.

A distrust of pastors by many, apathy on the part of some, and a genuine disrespect for the office of pastor has left the Mt. Olive Baptist church fragmented and disoriented. This is the context and foundational from which God is challenging the author to establish a non-traditional, forward-thinking ministry that embraces those disenfranchised and marginalized persons infected with and affected by HIV/AIDS.

The purpose and mission of this ministry project is to create an awareness of the state of the African American church and its response to the pandemic of HIV/AIDS within and outside its walls. It is also, to enlist the support and help of African American

churches in the fight against HIV/AIDS, by becoming willing partners in the dissemination, education, and referrals of resources within the community to better serve this population of people. All of the work documented in this ministry project occurred within the city of Dayton, Ohio, where the author was able to take advantage of numerous resources and collaborate with other professional agencies that work with the targeted population of persons with HIV/AIDS. However, the author was not as fortunate when dealing with some of the other members of clergy, especially those pastors, who thought that HIV/AIDS was God's divine judgment on persons who engaged in lewd behavior. The author simply asks the question, "where was God's judgment on the rest of us for some of the behavior we engaged in?"

However, the author did receive support from pastors whose hearts were after God and those who had a mindset to serve. These selected pastors, along with the author, encouraged their congregants to get involved, and along with health care professionals, a large number of persons participated in this ministry project.

The collaboration approach proved to be most effective in gathering persons together to attack a common goal with a variety of methods, including health care, prevention education, family intervention, support, and of course, testing. By utilizing the African American churches we were able to tap into an institution that was a foundational part of what most African Americans have known and trusted most of their lives. This was a critical concept, however not without risk. After all, many churches had turned their backs on and preached against many persons in this targeted group of participants. It was necessary therefore to shift the paradigm by doing some things differently. Part of the strategy included training staff to be participant-centered and focus solely on their

needs. Once some of the participants needs were met, they became more willing to engage in the project. Some of the needs addressed were feeding folks who were hungry, clothing folk in need, and distributing food for people to take home to assist in feeding their families.

The author recognized that many of the prospective participants were bitter about the way many of them or their loved ones had been treated at the hands of some of those who said they were all about love. To compensate for this type of treatment, the author along with other pastors, simply served the participants. They were greeted warmly by the author and others were not told who we were until after the service had been offered, many were astonished and much more receptive after seeing servant leaders in action. The author has a long history of service with the Dayton Urban League and many participants associated his service with that organization until they found out that the author was the pastor of Mt. Olive Baptist Church.

As previously mentioned, the rates of HIV/AIDS infections has never been higher among heterosexual African American females and they continue to climb. The African American church is heavily populated with heterosexual African American females. Research has shown that eight of ten people in the African American community have some contact with the African American church. The author intends to seize on this fact and create some momentum to educate, test, and refer to treatment those persons in need. The author subscribes to a statement issued by the Center for Disease Control that everyone should be aware of his or her HIV/AIDS status.

To this end, the creation of a ministry model: Preparing African American Churches To Develop HIV/AIDS Related Ministries: An Intervention Model For

Transforming African American Faith Communities, is the author's way of answering this calling from God on his life to fulfill that part of the scriptures in Matthew 25:45 when Jesus "said inasmuch as you did not do it to one of least of these, you did not do it to Me."

Developing the Model for the Ministry Context

The author will examine information from a variety of sources to develop this ministry model for the selected African American churches. This ministry model endeavors to prevent the spread of HIV/AIDS through education and testing for the HIV virus. The measures utilized in this model are more preventative than treatment oriented, however, anyone testing positive with the HIV/AIDS virus during this ministry project will be linked to service providers who specialize in the care of those infected with this virus.

Once the author completes this ministry model it can be easily replicated for other African American churches to adopt for usage in the neighborhoods where their churches are located. The author has recognized the need and planned for the training of the pastors of the selected African American churches and they will be given additional support for their churches throughout this ministry project and beyond.

The author's history working with this targeted group of participants has given him the insight necessary to effectively navigate through the require minefields to get the necessary results to best serve these individuals. The author has had numerous trainings and certifications in cognitive skills assessment, family counseling, and pre- and post-

HIV counseling, HIV testing, community organizing and planning that should serve the author well to develop and maintain this ministry project.

Statement of Need

The geographic service area, the city/county in which this service area is located, and AIDS case rate from the Ohio Department of Health estimates that up to 24,200 persons with HIV/AIDS live in Ohio, and at the end of June 2005 (Ohio Department of Health, 2006) there were 14,559 reported HIV/AIDS cases, and 8,382 deaths due to HIV/AIDS. With an HIV/AIDS prevalence rate of 171.7 per 100,000 population, Dayton/Montgomery County is among eight Ohio counties that have been hardest hit with HIV. African Americans account for 476 cases; making the prevalence rate for African Americans 419.1 per 100,000 (ODH, 2007). African Americans make up 19.9% of population compared to 75.9% of Caucasians in Dayton/Montgomery County, but accounted for 49% of the HIV/AIDS population.

Geographic Area Where Services Will Be Provided

Services for this ministry project will be provided in Dayton, the largest city in Montgomery County (population: 166,179). About 30% of the people in Montgomery County reside in Dayton. Over 53% of Dayton's population is Caucasian, 43.1% are African American, and 3.4% are of other ethnicity. This ministry project will focus on Dayton area residents and selected African American churches.

Meeting the Need by Co-Existing

The author believes that the most effective way to meet the needs of this targeted participant group is for the African American churches to allow this ministry project to share existing space with the church. These African American churches can take advantage of existing relationships within the community to shift the paradigm from being open only on Sunday to the church becoming a more viable entity in the community. These churches can better utilize space that is currently only being used one or two days a week by opening up to the community to educate, train, and test persons for HIV virus during the week, thus giving the church more visibility and allowing for a much-needed service in the community.

The author's challenge is trying to convince the African American churches to open their facilities to persons who may or may not belong to the church. African American churches have a tendency to be territorial and not too receptive to outsiders using their space. He is the foremost authority on the subject matter in the Dayton area and has been very successful in persuading other pastors to participate in the ministry project. He has offered assistance to other pastors to help secure funding for projects at their churches, another area of expertise by the author, expertise which the author brings to this project. Incentives always seem to make a difference in the willingness of pastors and African American churches to participate. The author is certain that he has put together a plan that will achieve maximum results as it relates to testing, educating, and referring infected persons to treatment at the selected African American churches.

CHAPTER TWO

THE STATE OF THE ART IN THIS MINISTRY MODEL

For I was hungry and you gave me food, I was thirsty and you gave me something to drink, I was a stranger and you welcomed me, I was a stranger and you welcomed me, I was naked and you gave me clothing, I was sick and you took care of me, I was in prison and you visited me. Then the righteous will answer him, 'Lord, when was it that we saw you hungry and gave you food, or thirsty and gave you something to drink? And when was it that we saw you a stranger and welcomed you, or naked and gave you clothing? And when was it that we saw you sick or in prison and visited you?' And the king will answer them, "Truly I tell you, just as you did it to one of the least of these who are members of my family, you did it to me. (Matt. 25:35-40)

A significant factor with many of our African American churches involved in this project is: who is the "least of them?" The definition of the "least of them" is related to any church's given theology. It would seem that the "least of them," by definition would be those persons in the minority of persons receiving needed services, those persons who have been marginalized and find themselves on the fringes of society. The question then is how Christians in the African American church can do the work of the church in the name of Jesus Christ and omit certain populations of people. If the African American church is to serve the least of them, then all segments of society must be included. In addition to the aforementioned categories, the African American church must include persons who are HIV-positive and living with the AIDS virus.

If this passage of scripture shall serve as a model for inclusiveness in the church then it must be further examined to bring clarity and definition to the work that must be done and who shall be served because of the work given to the church. James Cone gives the challenge for the mission that many churches have to encounter in light of the scriptures and the Jesus who is preached about in our pulpits.

Cone says, “to say that Jesus Christ is the truth of the Christian story calls for further examination. It is one thing to assert that the New Testament describes Jesus as the Oppressed One who came to liberate the poor and weak; but it is quite another to ask, who is Jesus for us today? If twentieth-century Christians are to speak the truth for their socio-historical situation, they cannot merely repeat the story of what Jesus did and said in Palestine, as if it were self-interpreting for us today. Truth is more than the retelling of the biblical story. Truth is the divine happening that invades our contemporary situation, revealing the meaning of the past for the present so that we are made new creatures for the future. It is therefore our commitment to the divine truth, as witnessed to in the biblical story that requires us to investigate the connection between Jesus’ words and deeds in first century Palestine and our existence today. This is the crux of the Christological issue that no Christian theology can avoid.”¹

For those persons in and out of the church charged with the responsibility to care for the disenfranchised persons on the margins of society, there must be a culturally specific adaption to this process. There can be no one size fits all or a cure-all for all of humankind without first considering the social locations of those persons in need. Surely, ideas, theories, churches, and schools must somehow relate to a cultural setting. Biblical scholarship was born and bred on European soil, and this means that European culture was common ground for the scholars themselves who explain many of the text we read. Biblical scholars traditionally had a very broad education and were often equally at home

¹ James H. Cone, *God of the Oppressed* (New York: Orbis Books, 1997), 99.

in at least one other field apart from the Bible. This becomes known in a preference for importing ideas and philosophies of the day into the Bible, reading ‘in’ rather than ‘out.’ Therefore, they seem to have abstracted more or less from their own background,² not focusing on the social location of many of the intended recipients for whom the gospel is directed. The absence of HIV/AIDS ministries in many African American churches seems to suggest that the European approach to Biblical interpretation is alive and well.

To note that there is no one size that fits all is of critical importance. Research has shown that there is no one African American church that provides all of the necessary services to person infected and affected with HIV/AIDS. Therefore, it will take a collaboration of churches to address an issue that is wreaking havoc in the African American community.

The author agrees that at the heart of the interpretation of Matthew 25:35-36 is what Vincent Harding wrote about in his foreword of Howard Thurman’s *Jesus and the Disinherited*. Harding wrote “although it is possible to glean elements of a liberation theology from its pages, this richly endowed, seminal work can be more accurately and helpfully described as a profound quest for a liberating spirituality, a way of exploring and experiencing those crucial life points where personal and societal transformation are creatively joined. It is the centerpiece of the Black prophet-mystic’s lifelong attempt to bring the harrowing beauty of the African American experience into deep engagement with what he called “the religion of Jesus.” Ultimately, his goal was to offer this humanizing combination as the basis for an emancipator way of being, moving toward a fundamentally unchained life that is available to all the women and men everywhere who

² Daniel Smith-Christopher, *Text & Experience: Towards A Cultural Exegesis of The Bible* (England: Sheffield Academic Press, 1995), 225.

hunger and thirst for righteousness, especially those “who stand with their backs against the wall.” Repeatedly he announced that he was attempting to explore and explain “what the teachings of Jesus have to say to those who stand at a moment in human history with their backs against the wall...the poor, the disinherited, the dispossessed.”³ It is precisely this type of focus that must be given to social location while interpreting a Biblical text, in order to bring about valid critical interpretation that can lead to successful application of the text for those affected persons described in the text. This kind of Biblical exegesis lends itself to the inclusiveness necessary to be reflective of the Biblical Jesus motif.

What then should the African American do about inclusiveness in response to the pandemic of HIV/AIDS that is devastating the African American communities in and around its churches? Should these churches get involved in the activity of speaking up against this societal disgrace or should they remain silent?

The HIV/AIDS epidemic continues to have a devastating impact on the African American community in the United States. Although African Americans make up approximately 12% of the U.S. population, they accounted for half of all new HIV infections reported in 2003.⁴ If something is not done in a hurry many of the African American communities will be decimated beyond repair. The current trends point to the lack of prevention, education and testing in the African American communities and gives credence to the theory of genocide of a culture by disease. In addition, many persons infected are either not aware of their status or fail to seek treatment.

³ Thurman, *Jesus and the Disinherited*.

⁴ CDC, *HIV/AIDS Surveillance Report*, 2003;15. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. 2004:6.

The impact that the epidemic has on African Americans underscores the need for novel intervention strategies to reduce HIV infections in this community. One area that has not been fully realized is the role that the church, one of the most trusted institutions in the African American community, could play in HIV/AIDS prevention.⁵ Numerous factors make the African American church an attractive setting for HIV/AIDS prevention. For example, the church has long served as a vital institution within the African American community, setting defining values and norms for community members.⁶ While the African American church has come together on several issues pertaining to the plight of African Americans, the issue of HIV/AIDS has separated many of these churches.

The church has also been a site of social activism and health education within the African American community. Leaders of churches are often viewed by community members as reliable sources of information and support, and they often have close contact with members of disenfranchised groups.⁷

Given the role and the importance of the African American church in the African American community, it has the potential to play a much larger role in health promotion and disease prevention. However, the African American church as an institution has often been reluctant to respond to the HIV/AIDS epidemic.⁸

⁵JR Ayers, "The Quagmire of HIV/AIDS Related Issues which Haunt the Church," *Journal Pastoral Care*. 49 no. 2 [1995]: 201-210.

⁶Jeffrey S. Levin, "The Role of the Black Church in Community Medicine," *Journal National Medical Association*. 76 no. 5 [1984]: 477-483.

⁷JM Tesoiero and DM Sampson, et al. *Faith Communities and HIV/AIDS Prevention in New York State: Results of a Statewide Survey*, Public Health Department. 2000;115:545-556.

⁸CJ Cohen, *The Boundaries of Blackness: AIDS and the Breakdown of Black Politics* (Chicago University of Chicago Press), 1999.

It is the author's viewpoint that if the African American churches do not get involved, their behavior dishonors the sacred position they hold in the African American community and is a disgrace to the high office that many of the churches leaders hold. Statistics from the Center for Disease Control have documented that when awareness and education of HIV/AIDS is prevalent, the rates of infection have decreased. It is therefore imperative that if the national news media and society as a whole has not taken up the mantle to disseminate this information it must be done by other means. The fact that this issue of HIV/AIDS among African Americans has not garnered more publicity is a national disgrace and should be completely unacceptable to those individuals and institutions who are charged with the duty to watch over the souls of the people God has assigned to them.

While many of the African American churches are responding to a multiplicity of issues surrounding HIV/AIDS, they are negligent in making the correlation with how these issues influence the contracting of the disease. Research has shown that there is a higher degree of disparity with regard to HIV infections among individuals who are homeless, substance users, and professional sex workers. These groups are not apt to seek out services and become a part of mainstream institutions that provide services to counteract the spread of disease. For this reason greater access needs to be created to reach these persons where they are. One of the African American churches in the selected group for this ministry project is located in a area that is used by professional sex workers. This is the kind of non-traditional access that can and must be created to reach the underserved populations in the African American communities. Of the greatest challenges faced by this population is access to treatment, education, and prevention.

Roadblocks to access do more to prevent people from the affected population than they do to help get people into services.

When society sets up guidelines that make it difficult to acquire the necessities afforded other persons, sub-cultures are created by the affected persons to receive what they need by other means. These sub-cultures then become breeding grounds for the spread of HIV/AIDS and other diseases. Sharing of needles by intravenous drug users, trading sex for drugs, crack houses, shooting galleries, are a few of the behaviors and places where some of this population have created a sub-culture in which they feel most comfortable in. These places can and should be countered by offering an alternative such as the African American church. Before this can happen, there must be a paradigm shift in the church. The African American church can create a safe haven for these persons and take advantage of the opportunity to educate, test, and get into treatment those persons seeking such services.

The African American church, by utilizing its resources and influence, can be a great asset that can serve as the bridge to connect these services to those persons who need them the most, yet are the least likely to receive them. The church must actively solicit volunteers from the army of soldiers in many of its congregations to participate in this war to be trained and then proceed to the battlefield to do the work of educating, testing, recruiting, and connecting to treatment those persons who are identified and willing to proceed through the process. The amount of work required by this project makes it necessary for the enlistment of volunteers in order to be effective in ministering to the needs of this population.

This is an important ministry for the African American church. While recognizing that churches are already very busy and engaged in various ministries serving and leading the people of God and that the perception of many is that more activity or one more responsibility may be too much. However, let the author suggest that this ministry must become a critical part of other ministries if we are to be successful in dealing with this issue of HIV/AIDS. Expanding what these churches already do to educate their congregation on health will allow the churches to have a more vibrant congregation with more people able to serve better. The time spent in educating these congregations on healthy practices will yield results that will last generations.⁹

The author recognizes the need to train the pastors and leaders of these congregations to get actively involved and create a priority from the pulpit about this issue of health and wellness to include all aspects that are damaging to the health of the community and the church. The author is familiar with the unspoken tradition in the African American church that if something is important, than it must come from the pulpit, otherwise, not much credence is given to the matter. By training, the head of church is first if there is a greater opportunity for successful teaching throughout the church congregation. This approach, if handled correctly, should create a passion that will be prevalent not only in the leaders, but the congregants as well.

For instance, if the congregation witnesses the pastor receiving an HIV test, teaching an HIV/AIDS educational class, or doing outreach to attract ministry participants into the project, then the congregation is more apt to participate in these kinds of endeavors. By leading the congregation into this fertile ministry ground, the

⁹ <http://www2.state.tn.us/health/faith>

pastor assures himself of more volunteers than might otherwise be available to assist the pastor in this kind of work. The author has experienced this type of result firsthand and can validate the results through his knowledge.

Ultimately, what one finds is that there is a peer to peer validation, where persons sharing the same demographics, can reach a segment that is often unreachable by outsiders. This could be the for African American women, the fastest rising demographic of HIV infections and the majority in most African American churches. Women from the churches can relate better to the historical issue of African American women being the primary caregiver in most African American homes. That being the case, African American women tend to take care of the needs of everyone else before they take care of their own. Such was the author's experience with his own mother and the author watched his grandmother perpetuate the same behavior with his grandfather. As a result of this embedded concept shared from generation to generation, when African American women do come to be tested and treated, they die at faster rates than their Caucasian counterparts. This author has participated in the design of this ministry project to ensure that it provided a sense of meaning, purpose, and urgency by understanding all of the emotional and spiritual dynamics associated with this disease. In addition, the design provided needed support, compassion, advocacy, and assistance for marginalized persons. Guidance is given to provide education on health-affirming practices to improve communal health. One of the biggest challenges has been to eradicate some of the past practices of our fore-parents.

There are varied views how to best attack this issue about HIV/AIDS from the perspective of the African American church. The central question remains, from whose

perspective do we operate this project? The Center for Disease Control believes in testing and education. Many churches believe that abstinence is the correct way to go, and the federal government position changes with every administration. The author has structured this project so that there a variety of approaches to attack this problem, but none more important than the inclusion of the African American church. The impact that the HIV epidemic has on African Americans underscores the need for this novel intervention in the community. The author has studied a plethora of approaches and methods, scientific and non-scientific, to this problem and has concluded that there is no one size that fits all of the various demographics of the targeted populations that must be addressed within the African American community.

To summarize, the African American church is the one area that has not been fully realized for its potential to make a difference in resolving this problem. The church, being one of the most trusted institutions in the African American community, could play a vital role in HIV/AIDS prevention. Historically, the African American church functioned as more than a place of worship. Foremost, it represents political independence for African American people. The African American church is a symbolic extension of the freedom and independence of all African American people.¹⁰ Within the church, there is freedom from external surveillance by the white majority and the decision-making rests entirely in the hands of African American individuals themselves.

¹⁰Wyatt T. Walker, "The Contemporary Black Church," in *The Black Church: A Community Resource*, ed. Dionne J. Jones and William H. Matthews (Washington, D.C.: Institute for Urban Affairs and Research, Howard University), 36-68 (This book comprises a selection of papers presented from a conference entitled "The Religious Experiences of Afro-Americans" at Howard University, June 3-5, 1976, Washington, D.C.).

Summary of How the Ministry Focus Works with the Peer Group Focus

This ministry focus seems to have resonated well from its inception with the author's peers. A clear passion and expertise made this project viable right from the start. After one of our peer sessions in Chicago, the author then understood why he resonated with his peers as well. The compelling force that brought us all to this point in our lives, and that we all recognized was much greater than the sum total of persons and projects, was God. Through a most inauspicious beginning this peer group began to bond though the challenges it faced were formidable, the peer group knew that it must see the projects through. The group did lose one member, but that was the exception and not the rule. Given the unforeseen circumstances, it is surprising that the group did not lose more.

The transition of mentors was difficult but somehow the group managed to forge on because they knew the potential outcomes were far greater than the pain they were currently experiencing. The author, after being persuaded to change his project focus, ultimately returned to where his true passion was and could not accept a project that he was not passionate about just to acquire another degree. The peer group was instrumental in this decision, as they had to make similar decisions as well. The author's title is *Preparing African American Churches To Develop HIV/AIDS Related Ministries: An Intervention Model For Transforming African American Faith Communities*.

A stable mentor provided much needed guidance and leadership to ensure that the group was able to proceed. Time and patience has a way of healing wounds, making it possible to continue to fulfill the goals that have been set.

Ministry Context Focus with Peer Group Support

The focus of the ministry project was to select the most viable entity possible to provide the necessary HIV/AIDS services to infected and affected groups of people. The majority of the group felt that not only should services be provided, but that they should be provided with the same dignity and respect as anyone else seeking such services, especially with respect to the high level of confidentiality that comes with serving persons with the HIV virus.

During the peer sessions, critical questions were posed to the author that stimulated deeper more meaningful thought about the scope of this ministry project. The author's focus was narrowed considerably to make the project more manageable, redirecting the focus allowed the author to leverage more resources in a more concerted effort.

This ministry project will establish partnerships with the appropriate stake holders that will assist with services and referrals to the appropriate agencies. This ministry project will also utilize the methodology of direct referrals where an individual can receive services from a predetermined service provider, thus eliminating the need for disclosure to unnecessary individuals. All efforts will be aimed at providing a quality of life for persons living with the HIV virus. These necessary services are provided in a manner that is highly efficient and necessary for not only connecting the people with services, but also with the church.

Personal Response to Ministry Focus

This ministry project is geared toward helping the persons infected and affected with the HIV/AIDS virus. The objective is clear—to shift the paradigm in African American churches to include HIV/AIDS in their health ministries, to provide a sense of belonging to these individuals and their families, and to end the needless suffering that people with HIV/AIDS are experiencing at the hands of those who know and love Christ. To this end, the author is committed to making a difference.

This collaborative effort has proven to be most effective. The sharing by mentors and others has resulted in a model that should be invaluable to those who choose to participate. After several failed attempts at providing the leadership necessary to move forward, the author was blessed to have angel sent from heaven to bring this ministry project to its conclusion.

In spite of the difficulties, the peer group has forged ahead because of the passion that exists from a committed group of folks who seek change for the downtrodden and marginalized persons their ministry project endeavors to serve. The author has been blessed to be in the company of the committed.

Summary of Ministry Focus

The peer group listened to noted preachers, scholars, teachers, and activists during the intensives, seminars, and worship services that inspired them to do their very best. The author was moved with compassion like never before. When faced with such a

daunting task and not sure how to proceed, this task was made easier by those who had gone on before them, who had proven successful on their own merits.

In conclusion, the needs of those persons infected and affected with the HIV/AIDS virus can be much more effective if the African American churches would assist in greater measure to fight against this disease. There were several factors necessary for the project to be deemed successful:

1. Open the church doors and invite education on HIV/AIDS for pastors, lay leaders, and congregants.
2. Set up satellite offices to assist in the referral process.
3. Provide opportunities for screening and testing.

This ministry project will be concluded when the author has developed a ministry model that Prepares African American Churches to Develop HIV/AIDS Related Ministries. The anticipated results are to shifts paradigms in the African American churches to become more inclusive.

CHAPTER THREE

THEORETICAL FOUNDATION

The focus for this doctor of ministry project is “Preparing African American Churches to Develop HIV/AIDS Related Ministries: An Intervention Model for Transforming African American Faith Communities.” The author intends to share a prescription for the African American church that will influence the lives of those persons infected and affected by the HIV/AIDS. The author recognizes that this virus affects other ethnic groups as well; however, the majority of new HIV infections are in the African American community, especially African American females who die quicker because of their roles as primary caregivers in the family.

In interviews with clergy about the universalism of the Christian ministry and its primary task of saving of souls, as one Baptist minister said in an interview, “The ministry of both black and white preachers is the same: the saving of souls. Skin color is of no great significance in relating the message of Jesus.”¹

On the other hand, the clergy who affirmed the distinctiveness of the black ministry stressed the problems of racism in American society and the different social, economic, and cultural conditions of African Americans, with which black clergy have to deal. One cleric said, “Black people have different needs, different concepts of what the

¹C. Eric Lincoln & Lawrence H. Mamiya, *The Black Church in the African American Experience* (Durham and London: Duke University Press, 1990), 170.

church ought to do. Since we are oppressed (we) have to deal more with what religion really means. We have to deal with practical needs.²

Another pastor replied, “Black folks have a different religious orientation from white folks. There is little emphasis put upon Home and Foreign Mission and Christian Education. White folks work from the building of their educational department, but black folks operate from the pulpit as great preaching stations. Great emphasis is put on preaching in black churches.” Other pastors stressed the independence of the Black church and its central role in the community. Ministry in a black denomination was different, said a Methodist preacher, “because of what the church means to the community as a center for black caring and social-political nurture. It is the one “free institution in the black community and lends the pastor the freedom to respond to problems and issues without fear.”³ However, the author has serious doubts about the validity of this freedom when it comes to the issue of HIV/AIDS.

The large female population of African American congregations suggests the church may be an ideal place for HIV/AIDS prevention and awareness programming tailored to the needs of African American women. This is especially critical because black women constitute a growing share of HIV/AIDS cases, representing 69% of the cases among women in 2003.⁴

The author believes that as a part of the prescription to help alleviate some of what troubles the African American church in regards to HIV/AIDS is to know the true

² Ibid.

³ Ibid.

⁴ Center for Disease Control. *Diagnoses of HIV/AIDS -32 states, 2000-2003*. MMWR. 2004;54:106-110.

work of the church and the true compassion of our Lord and Savior, Jesus Christ. This compassion supersedes our beliefs, denominational doctrines, prejudices, and any other thing that gets in the way of ministering to the least of them.

Beliefs and Worship in the Black Church

What doctrine has shaped the development and activism of the Black church? What are the elements of faith held across denominational lines that give the Black church its character and sanction its activities? How are these acted out within the local church setting? These questions point to the body of beliefs and ritual practices that undergird the institutional Black church and provide the parameters for what it means to be black and Christian for roughly 24 million black Americans.⁵

This pandemic of HIV/AIDS in the African American community has remained a priority for the author for several decades now. It has been the single-most compelling aspect of the author's life and will remain until major steps are taken to eradicate this awful disease.

When one seeks to know and understand God, there is no shortage of interpreting who God is and what God does. Different perspectives of God lead to a plethora of reasons for the way we believe and act. There are a variety of reasons for the approach to ministry, but the most common are traditions. Many people the author has encountered approach ministry with embedded theological and theoretical foundations that lead them to act on what they believe about God much in the same manner that their ancestors

⁵Anthony B. Pinn, *The Black Church in the Post-Civil Rights Era* (Maryknoll, N.Y.: Orbis Books, 2002), 37.

acted. At the core of this type of theological and theoretical hypothesis is if this kind of thinking worked for our ancestors, then it should be sufficient for us. Many people have not transitioned their theology into a 21st century application. David Satcher, MD, U.S. Surgeon General from 1998-2001, said “they (black preachers) speak about sex in any form as if it is cancer. We need the church to help us deal with the prejudice and the bias that we face as we are trying to fight this epidemic.”

“More devastating than the physical disease known as AIDS is the spiritual disease (Acquired Iniquity Devilish Sins). And the only way to kill its virus is to take dosages of the Word of God,” declared Robert Thomas, a Nashville newspaper columnist known as “The Road Scholar.”⁶

This simplistic analogy implies that those infected with HIV/AIDS are victims of their own spiritual failings. Such views, which proliferate among African American clergy, provide justification for some churches to withhold compassion from people living with AIDS. During the first decade of AIDS, some African American ministers refused to preside over funerals of AIDS victims, and funeral directors refused to bury them. Most African American clergy are more tolerant nowadays, though some pastor’s funeral homilies still diminish the AIDS victim’s spiritual worth.

Despite the toll AIDS is taking on the African American community, homosexuality has rarely been openly discussed in the African American church. Not only homosexuality, but also sexuality period. The author’s own experience spending life growing up in this church is a testimony to the lack of sexual awareness in any form.

⁶ Robert Thomas, “Heaven’s bleach will kill your AIDS virus,” *Nashville Pride*, October 18, 1997.

This does not mean that homosexuality is not condemned from the pulpit. On the contrary, outspoken anti-gay preachers do not hesitate to use the pulpit to condemn gay lifestyles. These pastor's homophobic stances hinder, rather than foster, the African American church's ability to address the growing AIDS epidemic in the African American community.

In order for leaders to respond to the suffering caused by AIDS. The African American church must work to overcome its own polarizing beliefs regarding the disease and homosexuality.

What Am I Required to Do?

Benjamin Mays said, "What can we, as black, do? It may that God has called upon black people, black Americans to a special people. It is my belief, it is my firm conviction, that God has sent every man and woman into the world to do something unique, something distinctive, and that if he or she does not do it, it will never be done and the world will be the loser. The call to do this unique thing does not go to the crowd or to the multitude but to the individual or a specific nation—mainly to a particular person and often a particular race. Yes, I do believe that God has sent every man and every woman into the world to do something unique and something distinctive, and if he or she does not do it, it will never be done."⁷

⁷ Benjamin E. Mays, "Thanksgiving" in *Outstanding Black Sermons*, ed. Milton E. Owens Jr. (Valley Forge, Pa: Judson, 1982), 3:50.

Embedded Theology

The gifts he gave were that some would be apostles, some prophets, some evangelists, some pastors and teachers. To equip the saints for the work of ministry, for building up the body of Christ.⁸

Ephesians 4: 11-12

If the African American church is going to make a difference in the fight against HIV/AIDS, it must take the aforementioned scriptures to heart. The author does not believe that an effective job has been accomplished of equipping the saints for the work of the ministry. As previously mentioned, the African American church is not speaking out on the issues of HIV/AIDS and homosexuality.

Since these issues are so prominent in the African American church, the saints must be prepared to deal with this vital part of the ministry to those who have been designated by society as the least of them. The author believes that one of the contributing factors that has led to saints being ill-equipped to deal with these issues is that of embedded theology. This is the baggage that most people are not aware exists until they are confronted with what they really believe, what they heard over and over since the time of their childhood, especially those things about people.

Children learn, for example, that being Christian means going to church for worship and knowing how to behave there—when to stand, sit, or kneel, and when to listen, pray, or sing. From words and action together comes familiarity with an entire set of meanings associated with the faith: good and bad; rituals and customs; and organizations, programs, and activities. Theological understandings are embedded in

⁸ *New Revised Standard Version: The New Oxford Annotated Bible With The Apocrypha* (Oxford University Press: New York, 1989).

these actions, no less than in the grammar and vocabulary of the language of faith. These theological messages from the church have been bred into the hearts and minds of the faithful since our entry into the church. Many of us were born and raised in this theology. It began in us before we could speak, developed during years of Sunday worship, church school, and youth groups, and was reinforced by the life example of our parents, friends, and ministers.⁹

Typically in the African American church, whatever the viewpoint of the pastor is generally the viewpoint of the congregation members. If the pastor held misogynist viewpoints about women in ministry, then so did the congregation. If the pastor held homophobic viewpoints, then so did the congregation. This historical perspective of the African American church with respect to these viewpoints rings true when one looks at the absence of HIV/AIDS-related ministries in the majority of African American churches.

Some find it easy to articulate the embedded theology they carry, but many do not. Ask someone: What is your concept of God, your understanding of sin or salvation, your account of the nature and purpose of the church, or your Christian view of right and wrong? Caught short by the question, some may come up with a pat answer. Or others may hesitate and stammer, unless they have stopped at some earlier point to consider the matter. And yet, day to day decisions are based upon this embedded theology. Christians pray to the God of this theology. This is the God they love or fear—and serve and sin against. Decisions are made at work and play, in families and in society according to the embedded understanding of God's message.

⁹ Howard W. Stone and James O. Duke, *How To Think Theologically* (Minneapolis: Fortress Press, 1996) 14.

Embedded theology is what devoted Christians have in mind when they say things like “My faith and my church mean a lot to me.” Wrapped up in such a simple statement is a host of associated elements—memories, beliefs, feelings, values, and hopes—not necessarily stated, and perhaps not at all clear.¹⁰

Embedded theology is also the stuff that makes for a great deal of real-world skepticism and indifference. Very few people shy away from Christianity because they have thoroughly examined all the arguments and conclude that its claims are not intellectually compelling. More commonly, they give up on the faith because of what they have gathered about it from the embedded theological testimonies or actions of other people and their churches. Most mental health professional and pastoral counselors have spent time tending clients who were scarred by what passed for Christianity in their homes or their homes churches.

It is embedded theology that rushes to the frontline in every battle over the moral and social issues of the day. Christians rise up to defend their theological convictions or express outrage when those convictions are threatened. Turn on the evening news and witness the two sides of the abortion question facing off: even their placards testify to their differing embedded understanding of faith. No wonder, then, that so many Christians laity and clergy alike, often act as though they are living in the trenches. They are!¹¹

Although this kind of embedded theological thinking has served its purpose throughout the ages, the author believes that embedded theological thinking has out-lived

¹⁰ Ibid.

¹¹ Ibid.

its usefulness. Too many persons have entered into the service of God with biases and presuppositions that do not allow for fresh thought to assist in carrying out the mission of the church. That mission, I believe, is clearly stated in Matthew 25:35-36, “For I was hungry and you gave Me food; I was thirsty and you gave Me drink; I was a stranger and you took Me in, I was naked and you clothed Me; I was sick and you visited Me; I was in prison and you came to Me. Then the righteous will answer Him, saying, “Lord, when did we see You hungry and feed you, or thirsty and give You drink? When did we see You a stranger and take You in, or naked and clothe You? Or when did we see You sick, or in prison, and come to You? And the King will answer and say to them, “Assuredly, I say to you, inasmuch as you did it to one of the least of these My brethren, you did it to Me.”

The primary function of the church is to minister to the least of them along with any others who are seeking guidance, strength, and shelter from a cold and heartless world. Whoever they are and wherever they are, they deserve to get the best God has to offer through his servants.

Deliberative Theology

Our embedded theology may seem so natural and feel so comfortable that we carry it within us for years. These beliefs remain unquestioned and perhaps even unspoken except when we join in the words of others at worship. We may be secure in the conviction that this is what Christianity is all about and leave it at that. Indeed, lay people are tempted to let their pastors take care of theological reflection, and pastors in

turn to let the church hierarchy or scholars handle it, but occasions arise that require us to think about our embedded theology, to put it into words and then subject it to serious second thought. Frequently, it is during crises that people first experience this call to theological reflection.

Deliberative theology is the understanding of faith that emerges from a process of carefully reflecting upon embedded theological convictions. This sort of reflection is sometimes called second-order theology, in that it follows upon and looks back over the implicit understandings embedded in the life of faith. By its very nature, second-order reflection is marked by a certain critical distance toward each testimony of faith. Deliberations are undertaken far removed from the more intensely personal viewpoint of embedded theology. Feelings, memories, and (to whatever degree possible) preconceptions are either set aside or evaluated along with other pertinent data, for the purpose of discovering insights that our narrower personal view might not allow.

Deliberative reflection questions what has been taken for granted. It inspects a range of alternative understandings in search of that, which is most satisfactory and seeks to formulate the meaning of faith as clearly and coherently as possible.¹² The theologian wants to take all the testimony and evidence under advisement, press beneath the surface to the heart of the matter, and develop an understanding of the issue that seems capable at least for the present of withstanding any further appeal. This is deliberative theological thinking.

The author firmly believes that too much surface thinking in the African American church has led to the demise of innovation in application of progressive

¹² Ibid.

ministry. The movement from embedded to deliberative theology thus creates a paradigm shift that allows the pastor and the congregation to move forward in service to all of God's people.

Many of God's people share in and yet do not recognize how Christians can move from one theological position to another. For example, a toddler wanders too near the edge of his grandparent's swimming pool, falls into the water, and drowns. The family's tortured outbursts, "Why did God allow my child to die? Why couldn't God let me die instead?" expresses the issue of theodicy, or the problem of evil and misfortune coexisting with a God who is all-powerful and altogether good. Their embedded theology leads them to state their anguish in such terms, but their "Why?" indicates that at this very moment they face a question of faith for which their embedded theology had not fully prepared them.

They are in desperate need of comfort, to be sure; friends may try to console them with the thought that their faith will pull them through. However, they also desperately need to understand. This life crisis is also a theological crisis; real death cannot be processed in bromides or vague abstractions.

When such a crisis abates, some may put behind them the issue that stemmed from that crisis. But many others will want to pursue it. In so doing, they are led to give serious thoughts to their initial understanding of the faith and so enter into the realm of deliberative theology.

Theological Foundation

African American Christians acknowledge the Bible as the primary source of information and inspiration in matters of faith and practice. Biblical narratives and spiritual principles form a large portion of the prevention message that could be preached and taught in a large number of African American churches weekly. The author is in no way attempting to stereotype a population of people, nor is he suggesting that all African American churches share the same beliefs. The author is simply suggesting the African American churches as a viable and acceptable vehicle to communicate the HIV/AIDS prevention message.

The church is the place where people expect to encounter God. The church is also a community. People who congregate each week know each other; they know each other's lives. It is not unusual for one church to have been attended for years by one family, so that the same pastor might baptize, marry, and bury the same individuals. (The author's current context is just this kind of scenario.) Imagine how this kind of reality brings up the tremendous potential of the church as a nurturing community and the importance of its role in helping young and old alike to heed the cautions and reap the rewards of HIV prevention education.

This role is especially critical in the case of youth and young adults, the population with one of the fastest rising rates of infection. The church has a compelling mandate to implement creative strategies to intervene in this most tragic of circumstances; the slow, pulling away of young people from the church and their swift succumbing to the materialistic, often destructive throes of popular culture. If it is true

that “the children are our future,” then African American churches must be ready to contend for their minds, bodies, and spirits with all the weapons that spiritual warfare makes available. An educated congregation is one of the most potent weapons.

As previously mentioned by the author, theology is a school of opinions concerning God and religious questions. Many theologians believe that interpretation of the Biblical text is a privileged position; however, the author believes that social location ought to play a prominent role with regard to interpretation of the Biblical text. We live in an age of professionalism. We are use to lawyers to do our legal work, doctors to take of our health, teachers to educate our children.

In more recent times we have developed more professions: economists to explain and mange the economy, engineers to make and run our elaborate technology, and managers to order our organizations. We have morticians and beauticians, psychotherapists and dieticians, agronomists and journalists, and on and on and on. We become dependent on others even with respect to things that we could do for ourselves. We turn to experts in everything except what we are expert in ourselves. No one seems to have the whole picture, to know how all the parts fit together. Many jobs get done better through this specialization, but as human beings we are in some way diminished. We take less responsibility for whom and what we are.¹³ The African American church must shoulder the responsibility of its people and not pass this responsibility onto other entities such as government and social service agencies. The African American church must deal with this issue itself.

¹³ John B. Cobb, Jr., *Becoming a Thinking Christian* (Nashville: Abingdon Press, 1993), 11.

All Christians are theologians. It is not that they were born that way or decided one day to go into theology. It is a simple fact of Christian life: their faith makes them theologians, whether they know it or not, and it calls them to become the best theologians they can be.¹⁴ This shift in thinking is precisely what is needed to move to the inclusiveness of all persons in ministering to the least of them and everyone else.

While it is important for Black people to adopt rigorously a new critical stance toward traditional or prevailing exegetical methods and hermeneutical conclusion, more is required. People must seek to liberate themselves from the popular tendency to deify the Bible as the definitive and exclusive Word of God, as if God's entire revelation only exists in the canon of Biblical literature. To be sure, the Bible does represent a foundation for the word of God. Moreover, from the faith claims of the biblical tradition, the Bible does constitute the most important ancient locus for the Word of God. However, even this is not synonymous with the view that the Bible is categorically the Word of God.¹⁵

One fact that demands a more modest assessment about the Bible as God's only Word is the long, often torturous process whereby Hebrews/Jews and Christians arrived at their respective canons. Within this mundane history, we encounter communities of faith struggling for centuries to make sense out of human existence, or, to be more accurate, their own particular human existence and their specific perceptions about their place in God's plan of salvation.

¹⁴ Stone, *Think Theologically*, 1.

¹⁵ Cain Hope Felder, *Troubling Biblical Waters* (Maryknoll, NY: Orbis Books, 1989), 14.

As historical vicissitudes bring changes, the content of revelation seems to change. Thus behind the collection of books that became the Hebrew Bible, Septuagint (Greek Old Testament), and the Greek New Testament is the very complicated process of canonization. Many inspired books, “holy writings,” gospels, and epistles were ignored and omitted, often for reasons that were quite arbitrary, dogmatic, and certainly not scientific.¹⁶

It is precisely for these reasons that the author believes that the African American church must reevaluate its stance with respect to how it treats persons infected and affected with the HIV/AIDS virus. If the supposed stance by the African American church for operating the way it does is the word of God, then the word of God must be fully examined.

Historical Foundation

When we recollect that most of the early emigrants to New England came from their fatherland in search of “freedom to worship God,” we are not surprised to hear Cotton Mather saying, “Many of the first settlers in Massachusetts were Baptists, and as holy and watchful and fruitful and heavenly a people as perhaps any in the world.”¹⁷ Specifically, Baptists of America trace their primary roots to the work of Roger Williams, the first who pleaded for liberty of conscience in America and who became the pioneer of

¹⁶ Ibid.

¹⁷ Leroy Fitts, *A History of Black Baptists* (Nashville, TN: Broadman Press, 1985), 22.

religious liberty for the New World. The rise of Baptists in America has a strong claim to the status of indigenous denomination.

The tremendous influence of Roger Williams in the birth of Baptists in America is a matter of great significance to the subsequent development of the sociopolitical thought among black Baptists. Governor Hopkins once remarked: “Roger Williams justly claims the honor of having been the first legislator in the world, in its latter ages, that fully and effectively provided for an established full, free and absolute liberty of conscience.”¹⁸ Having been a Puritan minister, Roger Williams was driven from England by those persecutions of opinions, which, like the confusion of languages at Babel, drove men asunder and people the earth. When he arrived in Massachusetts, Williams proclaimed that the only business of the human legislator is with the actions of man as they affect his fellowman; but, as for the thoughts of his mind and the acts or omissions of his life as in respect to religious worship, the only lawgiver is God; and the only human tribunal is a man’s own conscience.

National Baptist Convention of America, Inc.

“National Baptists” has been the name of the some aspect of organized black Baptist life since 1886, at the latest. During the three decades following the Civil War, both the longtime free and the recently freed Baptist of African American descent were developing their public life, including organized church life. By 1876, all of the Southern states except Florida had a state missionary convention, but smaller bodies had existed

¹⁸ Ibid., 23.

since the 1830s in the Midwest, and organized missionary efforts date back to that same period in the North.¹⁹

These institutional efforts matured in 1895 when the National Baptist Convention, U.S.A., came into in an Atlanta gathering. For the next 20 years, a single National Baptist body functioned through a variety of activities. One major body was responsible for the publishing of Sunday school material. Also, they sponsored foreign mission enterprises especially to African and Caribbean countries. They founded some colleges and provided support for others, several of them the result of dedication to providing education for the emancipated people on the part of Northern churches, Baptists, and others.

Then, in 1915, a schism occurred that produced two National conventions. The one being described here, the NBC of America, Inc., was originally known as the NBC. (It incorporated in 1988.) The other took NBC, U.S.A., Inc., as its name. The occasion for the separation was conflict over legal ownership of the publishing house. The “of America” segment followed the Boyd party—that is, the leadership of the Reverend R. H. Boyd. The other sector took the side of the Reverend E. C. Morris, who had been National Baptist president since 1897. These two National Baptist groups have often collaborated in missionary and educational efforts, but they remain separate conventions. Both bodies number many urban as well as rural churches, reflecting demographic shifts, the “of America” convention has a larger number of small rural congregations.

The National Baptist Convention of America, Inc., reports a membership in excess of 3,500,000. Its greatest strength is in the Mississippi, Texas, and Louisiana areas, with large numbers of members also in Florida and California. It holds an annual

¹⁹ Frank S. Mead, *Handbook of Denomination in the United States* (Nashville, TN: Abingdon Press, 1975), 68.

convention, and officers are elected each year. There is no central national headquarters, but Nashville, Tennessee is the home of the publishing house.²⁰

National Baptist Convention, USA, Inc.

This, the largest body of black Baptists in the U.S., shares a common history with the “of America” denomination (just described) throughout the formative years. Its formal origins date from 1895, with many roots and predecessors stretching back to the period around 1840. Until the disagreement that arose over control of the publishing house of the denomination in 1915, there was a single National Baptist body. Once the “of America” convention was created, the Foreign Mission Board became the “U.S.A.” body center of operations.

Now numbering more than 7,500,000 adherents, the U.S.A. body has widespread distribution. In 1990, it opened its World Headquarters in Nashville, where a section of the publishing industry has been located since the 1890s, and where its Sunday School Board is still located. Nashville is also the home of a seminary that has been operated (jointly with the Southern Baptists) since 1924. This convention meets annually, and its officers are elected annually. Those officers and a Board of Directors with 15 members conduct the Convention’s business.²¹

If publishing control has been the most conspicuous fact in the “of America” body, presidential influence has been “the U.S.A.” body’s most visible feature. That was

²⁰ Ibid., 69.

²¹ Ibid.

particularly true during the tenure of Joseph H. Jackson (1953-82). A powerful and effective leader, Jackson promoted the theory and practice of racial uplift in the tradition of Booker T. Washington. “from protest to production” was his motto. It followed that he led the body to steer clear of political and social involvements on any large scale. That policy placed this group mostly outside the civil rights movement of the period 1954-72, when many black Baptist pastors and lay leaders were deeply committed to working for racial and social justice through that medium. As a result, another National Baptist schism occurred, out of which the Progressive National Baptist Convention was formed in 1961. Since that period, however, this once less publicly involved body has shifted its practice and has been active in civil rights causes and voter registration drives.

This denomination, too, has been active in missionary, educational, and publication ministries. Recently, it has established a ministerial pension plan. It has shown a particularly high degree of commitment to the support of colleges and seminaries. These educational institutions are supported by Baptist churches and people rather than being officially Convention affiliated.²²

It is the author’s opinion that that division that many people experience in and from the body of Christ was never intended to be that way. Many persons, especially those with HIV/AIDS, are among a group of people who have, in many instances, been unofficially excommunicated from the church. Many churches are of the opinion that God’s rightful judgment has been rendered on the affected persons and they got what they deserve.

²² Ibid., 70.

In this endeavor to look at what is going on with respect to HIV/AIDS ministries and how persons with this disease are treated within the church, the author has focused attention on the part of the church that he is most familiar with, that being the African American church. The African American church's commitment to dealing with illicit drugs is evident in word and deed. However, the HIV/AIDS epidemic has not been as unilaterally addressed. Silence on this issue is often considered appropriate because many black Christians entertain conspiracy theories related to HIV/AIDS that promote suspicion concerning the disease and the medical industry's research and treatment efforts. According to some accounts, this disease entails a governmentally-engineered plot to remove undesirable populations, notably homosexuals, drug users, and racial minorities. The appeal of conspiracy theories, however, is not without some merit when one is mindful that earlier this century, black men infected with syphilis remained untreated in order to study the effects of the disease on the human body and mind.²³

For years, black leaders ignored AIDS, regarding it as someone else's fight. Like lepers, African American families affected by AIDS bore the shame and burden alone. Beyond conspiracy theories, for some churches HIV/AIDS is theologically problematic, particularly in light of the rather faulty ontology of AIDS fixed on sexual conduct embraced by most. Many black Christians assumed that God's involvement in the world as outlined of that disease. Why did it appear? Was it sent? Why is there no cure? Why is it uniformly fatal? Why are we seemingly powerless over it? Why does God allow it to continue unchecked? What does it mean? These are questions of theology and theodicy, power, will, purpose and providence, and even ego. Undoubtedly, these are

²³ Pinn, *Black Church in the Post-Civil Rights Era*, 98.

questions of tremendous complexity; for AIDS presents one of the most complicated interrelationships between potentially conflicting theological constructs: our theologies of disease, faith and healing; our theologies of lifestyle and personal responsibility; and our theologies of sin and salvation.²⁴

²⁴ Ibid., 99.

CHAPTER FOUR

METHODOLOGY

Ministry Project Design

The author's hypothesis is that the lack of consistent, factual information and education about HIV/AIDS has been problematic in that its impact can be clearly demonstrated by the lack of wellness ministries in the African American church and the rising rates of infected persons in and outside of the African American church and the rising rates of infected persons in and outside of the church in African American communities where many churches are located. Specifically, this ministry project design will focus on information and education shared by the African American church on the effects, cause, and eradication of a devastating virus that is one hundred percent preventable.

Thus the ministry project design and foundation will be pre- and post-assessment of the wellness ministries, their creation, equipping, and sustainability to address and impact the rising rates of infection of the HIV/AIDS virus, the lack of education and information in the African American church on HIV/AIDS, and the unwillingness to receive those infected and affected persons into fellowship with the mainstream of most congregations. The author believes that a needs assessment of congregations will reveal

issues that need to be addressed, to bring about meaningful change in the African American church and as a result of having received this assistance, the author believes that the African American church can truly be transformed into a place of healing and wholeness.

The ministry project design will assess pastors of selected churches in the Western District Association to ascertain their readiness to deal with the issue of HIV/AIDS and its impact on the church and community. Focus groups will be conducted and educational workshops provided to give factual information on the HIV/AIDS virus. The pre-assessment on knowledge of the HIV/AIDS virus will be given first, followed by educational workshops and post-assessments. After the conclusions of the educational workshops, trainings will occur on establishing wellness ministries in churches to include HIV/AIDS information and referral. All educational workshops, assessments for pastors, and congregations will be followed by post interviews on all subject matter presented to the churches.

Research methods used to test the ministry project design will include evaluation of all pre- and post-interviews, sermons by pastors borne as a direct result of participation in this endeavor, pre- and post-group briefings and debriefings, and surveys.

Outcomes

It is anticipated that the following outcomes will be achieved through the ministry model.

1. Participants who are seeking information on HIV/AIDS will gain access to this information as well as other health-related information through their local church.
2. Participants who are HIV-positive will be able to get admission into treatment.
3. Participants who are HIV-positive will learn that being diagnosed with the HIV virus is no longer a death sentence.
4. Participants who are HIV-positive will learn that with proper medication and diet they can maintain a quality lifestyle.
5. Participants who are HIV positive will have opportunity to become peer educators and recruiters for others to be screened and treated for HIV.
6. There will be establishment of satellite offices in cooperating churches to provide information and education to neighborhood participants.
7. Participants will learn how to accept those person who have been marginalized and disenfranchised into their fellowships.
8. Participants will learn how to find testing, treatments, interventions, and coping strategies that will help persons with HIV/AIDS.
9. Participants will learn that persons diagnosed with HIV/AIDS can still be productive, contributing members of society.
10. Participants will be able to realize that being diagnosed with HIV/AIDS does not make a person inferior.

Data Collection: Methods and Techniques Used

Action Research, a qualitative research method, is social research carried out by a team encompassing a professional action researcher and members of an organization or community seeking to improve their situation. Action Research promotes broad participation in the research process and supports action leading to a more just or satisfying situation for the stakeholders.¹ Together, the professional researcher and the stakeholders define the problem(s) to be examined, co-generate relevant knowledge about them, learn and execute social research techniques, take actions, and interpret the results of actions based on what they have learned. Action Research rests on the belief and experience that all people, professional action researchers included, accumulate, organize, and use complex knowledge constantly in everyday life. This belief is visible in any Action Research project because the first step professional action researchers and members of a community or organization take is to define a problem that they seek to resolve. They begin by pooling their knowledge. Action Research democratizes the relationship between the professional researcher and the local interested parties.²

This research design is particularly conducive to the author's style for multiple reasons. First, the author has been personally affected by the absence of HIV/AIDS education, treatment, and referrals for service in the African American church through the loss of two family members due to the HIV virus who attended African American churches. Second, the author is Pastor of a historically African American church with a

¹ Davydd Greenwood and Morten Levin, *Introduction to Action Research: Social Research for Social Change* (Thousand Oaks, CA: SAGE Publications, 1998), 4.

² Ibid.

traditional perspective on dealing with social issues that adversely impact the African American community. This is significant because the author has a strong personal commitment to bringing about improvement and empowerment in the lives of those persons adversely by not having access to information, education, and health care services that could make the difference in longevity of life. Moreover, the author feels that he assists in shifting paradigm from traditional thinking and approaches to more progressive and aggressive thinking concerning social issues such as HIV/AIDS by modeling a behavior that includes the least of them in ministry.

Additionally, qualitative methods involve examining and explaining observation in order to discover underlying meanings and patterns of relationships. Furthermore, qualitative methods provide richer, more in-depth data that reveal subtle nuances sometimes missed by qualitative approaches. Matthew Miles and A. Michael Huberman report that well collected qualitative data focus on naturally occurring, ordinary events in national settings so that researchers get a firm grip on “real life”.³ This research method works well in this context. Participants will be able to be observed while undergoing scheduled classes and events. Field research will be utilized in the assembling of qualitative data. This process will allow the author to study the participants during their national state while undergoing this process of receiving information that will transform their thinking process about HIV/AIDS.

The author will take field notes for later analysis. The data display approach to analysis will be used. Data display gives an opportunity for organized compressed

³ Matthew B. Miles and A. Michael Huberman, *An Expanded Sourcebook: Qualitative Data Analysis*, 2nd ed. (Thousand Oaks, CA: SAGE Publications, 1994), 10.

assembling of information that allows opportunities to look at a display, to understand what is happening, and to take action based on that understanding.

The ministry project design includes the convenient sample of five African American churches within the Dayton, Ohio community. These churches were chosen because the pastors of these churches have shown a keen interest in dealing with the impact of HIV/AIDS on the African American community. These pastors are also some of the most active pastors in the city of Dayton and know how to effectively communicate a message with the great urgency that this message deserves. Before the ministry project is discussed in depth, the author would like to share some specifics about the role of the church.

The Church's Role in HIV Prevention

African people through the world are at war with the Human Immunodeficiency Virus (HIV), the causative agent for Acquired Immunodeficiency (AIDS). The AIDS epidemic has preyed upon fear, ignorance, lack of leadership in mobilizing prevention strategies, and non-support of people infected and affected by the disease. Throughout the world the AIDS epidemic is completely out of control. Every day approximately 5,000 individual worldwide become infected by HIV. In Uganda, 10,000 new cases of AIDS are reported each month, and already 500,000 children have been orphaned in that country. Over 60% of the world's AIDS cases are found in sub-Saharan Africa. In the United States over 75% of all women infected with HIV are African Americans. The infection rate among black teens in the United States doubles each year. Wherever AIDS

is present, whether in South America, Europe, North America, Australia, Asia, or in the Caribbean, statistics reveal that Africans and those in the African Diaspora are disproportionately affected by HIV/AIDS.

The sad fact of the matter, as previously stated, is that AIDS is 100% preventable. The question must be asked, therefore, why does this disease continue to wreak havoc in our global village? The World Health Organization (WHO) has projected that between 1995 and 2000, between 38 and 110 million adults will have become infected by HIV. Again, the author reiterates that AIDS is 100% preventable and yet is completely out of control.

Many factors contribute to the AIDS pandemic in the African global community. Poverty is perhaps the greatest of these, for often, African peoples, regardless of nationality, are faced with sub-standard living conditions under which sickness and disease are more apt to spread. Poor people are also likely to be without adequate health care and adequate health education.

HIV is transmitted through sexual contact and by blood-to-blood contamination via blood transfusion and sharing needles when engaging in illicit drug activities. Sexual contact is the primary mode of transmission of infection among African people. Sexual health, sexuality, abstinence and related topics, therefore, must be openly discussed in our homes and in our churches. In order to prevent the spread of HIV, we must be able to talk about sex with our children and face realities concerning the level of their sexual activity. We must also examine our own sexual behaviors and put to rest the vestiges of sexual myths. Education is the most effective weapon against HIV. We must provide educational materials, therefore, that are culturally relevant and spiritually focused.

Combating HIV requires bold, steadfast leadership. To stop the escalating slaughter of African peoples by HIV, we must seek and receive leadership from the church. The church remains the cornerstone of the African global community. The church is the only institution that has the ability to mobilize the masses and disseminate appropriate information. It can be effective in doing so because it still enjoys the respect and the support of the people. In the face of a disease that is 100% preventable, churches must begin to provide prevention education and to support those persons who are infected and affected by HIV. No longer can we afford the luxury of succumbing to the “NIMBY” syndrome: “not in my backyard.” Only when churches are willing to admit that people living with AIDS are not “them,” only when our churches recognize that AIDS is not, by any stretch of the imagination, confined to those outside the faith community, can we begin to be effective. We look out over the casualties of the AIDS war—children homeless and orphaned; teens who for lack of information will become infected and who will not live to be 25; mothers suffering from abuse and obligated to have unprotected sex with their husbands who are known to be infected. We are numbed by the chilling fact that there is neither a vaccine nor a cure. All this causes us to ask the question: Is there a balm in Gilead? The answer is “yes.” The church, if we take the appropriate steps to organize, mobilize, educate and reach out, we can indeed be the balm “that heals the sin-sick soul.”

The session will be broken down into several breakout classes as follows:

Program Development and Evaluation

Purpose: To reduce the impact of HIV/AIDS on the African American community.

- Need to document the lack of HIV/AIDS- related health ministries in African American churches (and those factors it impacts, e.g. physical/mental health) and HIV/AIDS outcomes (seroprevalence, HIV knowledge, sexual practices, HIV testing) at baseline and follow-up.

Goal 1: To improve access to HIV screening and other ancillary services through the establishment of neighborhood faith-based satellites in African American churches.

- Need to document HIV testing (including where tested and how often), HIV medical care utilization of ancillary services (including what services and where received), utilization barriers of different services (e.g., barriers to HIV testing) at baseline and follow up.
- Need questions to assess the impact of services performed at an African American church (e.g., If you could not receive services at a church, would you receive them at all? Does having services provided through a church reduce barriers to service delivery)? Research Question: Does a neighborhood faith-based satellite in an African American church improve access to services?

Goal 2: To enhance substance abuse treatment for the target population through the provision of evidence-based practice, HIV, and ancillary services coordinated within the Dayton community through faith-based satellite centers.

Services to be provided (service provision must be documented for project participants and non-participants):

1. Case management
 2. Support groups
 3. Outpatient substance abuse treatment
 4. Health education
 5. Rapid HIV testing (mobile unit at multiple locations)
 6. Food/clothing pantry
 7. Community service referrals
- Need to document how often these services are offered.

Issues to Address:

1. Recruitment
 - a. What additional sites will be set-up as recruitment sites to better serve the entire Dayton community?
 - i. Are there other faith community opportunities to recruit, other than the African American churches?
 - b. Recruitment process
 - i. What staff are responsible for recruitment?
 - ii. Can we utilize church volunteers?
 - iii. Screening process (Brief HIV Screener) How will the highest risk persons be identified? What instrument will be used?
2. Client process
 - a. When/how evaluation instruments are completed.

- i. Need to determine when discharge interview should be completed (especially for clients who stop attending treatment, but have not been officially discharged).

3. Intervention/service provision details

- a. Strength-Based Case Management–Documentation of SBCM services
provided, length of case management, client impression of case management services. Need to create case management plan & service logs to document service.
 - i. Monitor fidelity of implementation
- b. Social Networks 1) the family/friend networking of high risk individuals through faith-based entities can offer all project services, thereby lowering risks for the primary clients, and 2) improve access and recovery support for participants. What are the interventions under “social networks” other than support groups?
 - i. Create process for inviting family/friend network of participants to join project, documentation of the number of people invited, demographic/risk profile, link family/friends to original client; assess impact of family/friend participation in project, reduced environmental risks related to risky sexual practices.
 - ii. Implement plan for support groups & documentation of these groups.
- c. Health Education–Modify HIV 101 curriculum to fit faith-based entity and enrolled participants.

- d. Rapid HIV Testing–Documentation of all HIV testing at the church (number tested, demographics) and documentation of which participants are tested, including results.

4. Evaluation

- a. Track recidivism beyond self-report.
- b. Document: 1) barriers to treatment, as well as barriers to receiving HIV/AIDS-related services; 2) HIV knowledge, 3) and treatment history, 4) sense of community (social network connections); especially faith-based before/after intervention.
- c. Track the services clients are referred to and actually receive.
- d. Track and individual and group outreach associated with this project.
- e. Must track services provided to non-eligible persons.
- f. Need to cluster clients into intervention dosage categories and compare outcomes across these categories

Behavioral Outcomes

It is the author's intention to maintain contact with the pastors primarily and then the participants who are identified as having high risk behavior for a minimum of six months in the ministry project as it is difficult to affect lasting changes in shorter periods of time as it relates to ministry goal and objectives.

Therefore, the author will also conduct a number of outcome measures among pastors and participants to evaluate (e.g., total number of sermons preached on

HIV/AIDS, number of Bible studies taught on the subject, total number or resource connections to testing, treatment, counseling, etc.). These outcome measures will be further defined, investigated, and analyzed in collaboration with the author, pastors and ministry project participants from the five selected African American churches. Follow-up to the data collection process is absolutely critical to ensure that whatever gains are made during the is ministry project are not lost due to inactivity.

As stated earlier, the author is also pastor of one the five African American churches selected for this ministry project. As pastor, the author believes that his role is to create an atmosphere that is conducive to promote, without fear, a platform to change the dialogue among pastors in African American churches with respect to the HIV/AIDS education through their pulpits and in their churches.

The author is tired of feeling a lot like Cassandra. June Osborn was the Chair of the President's Commission on AIDS and gave a speech in 1991 at the Seventh International AIDS Conference in Florence on the topic of "Feeling like Cassandra." Cassandra was the Greek heroine who heard the warriors inside the Trojan Horse, but, because no one would listen to her, failed in her efforts to warn her city about the hidden invaders. Osborne was feeling a great deal like Cassandra then, and the author feels a great deal like Cassandra now. When Osborne started to do AIDS research in 1986, she used to say in speeches "African Americans account for 12 percent of the U.S. population but twenty-five percent of the people with AIDS." Each year she watched the difference grow: Dorie Gilbert, writing in 2002, opens her book by pointing out that African

Americans make up 13% of the U.S. population, but over 50% of newly diagnosed cases of AIDS. The numbers each year get worse. Like Osborne, we all feel like Cassandra.⁴

When the author surveys the landscape of the African American church today, the author is convinced that this church is a microcosm of African American society as a whole. Many persons who have survived their past woes, persons looking for a fresh start, many people who have been cleaned up and who have erased the memories of a near tragic past. Many African Americans who are living with HIV/AIDS and the stigma that goes along with it, experience a tragedy they may never escape and in many cases through no fault of their own; a tragedy that the African American church can and must do something about. One such case to note is that of Malkia.

In 1992, when Malkia learned she had tested positive for HIV infection, she thought there must have been a mistake. As a single, African American woman in her mid-thirties who had just earned her college degree, she did not see herself as someone who fit into an “at risk category”. Although she had unprotected sex in the past, she was not an injection drug user. Yet now, engaged to a man with whom she had been practicing safe sex, she received this devastating news.⁵

Like Malkia, many women, including those inside as well as outside the African American church are not fully aware of their risk for contracting HIV/AIDS. Because so much of the news in the early years of the epidemic focused on gay men and injection drug users, the story of the steady rise in HIV infection among African Americans has

⁴ Mindy Thompson, foreword to *African American Women and HIV/AIDS*, (Westport, CT: Praeger Publishers, 2003), ix.

⁵ Women and AIDS, http://www.aid.harvard.edu/news_publications (accessed, November 7, 2007).

gone relatively unnoticed, even among health care professionals. The threat is greater now than ever before for African Americans in all lifestyles. At risk, behavior has to be redefined because what once applied, no longer holds true in many cases of how African Americans contract the HIV virus. Many African Americans, especially many heterosexual African Americans in trusting, loving relationships are finding themselves positive with the HIV virus. These African Americans are not in the traditional high-risk categories and many of them are in African American churches. They are wives, husbands, and the girlfriends and boyfriends of intravenous drug users or person in denial about their bi-sexuality.⁶

Bi-sexuality poses the greatest threat and produces the highest risk, especially men in the category who have unprotected sex with other men. The danger is greater because the men who have unprotected sex usually do not tell their heterosexual partner unless they absolutely have to, or when it is too late to effectively fight the virus. In addition, the fact that for a brief period in the 1990s there was a decline in new cases has led to a dangerous new complacency about HIV. The trust displayed by many African Americans in their relationships is costing them their very lives. The big picture for many African Americans is dim.⁷

Ethnic-minority gay men and lesbians frequently experience a sense of alienation because of the double-stigma they encounter from the larger White society and within the White dominant gay society, as well as within the African American community. This alienation leaves them at greater risk of isolation, feelings of estrangement, and increased

⁶ Ibid.

⁷ Ibid.

psychological vulnerability. The African American church has played an active role in alienating gay males based on biblical beliefs that homosexuality is a sin, while simultaneously embracing them, albeit in a secretive manner, as the “archetypal gay male in the church, usually involve in music production and singing”.⁸

The phenomenon known as the “paradox of the open closet” by Fullilove and Fullilove (1999), that gays have a creative role in the church is widely known, yet they are denounced from the pulpit with harsh, degrading condemnation. They argue that this has resulted in traumatic losses for gay men, including loss of peace through spiritual renewal and loss of self-esteem, in addition to their increased involvement in heterosexual relationships to maintain status within the community.

Because of their need to remain connected to family and community, African American gay men and women may be more inclined to engage in heterosexual relationship and or identify as bisexual. A higher proportion of HIV-positive African American men with AIDS were bisexual compared with their white counterparts.⁹ It is precisely for these and the other reasons alluded to that the author has designed this ministry project to impact this community and body of believers in the African American churches like never before.

As a matter of convenience, and as stated earlier, African American participants who access the five African American churches in the ministry project will be recruited to participate.

⁸ Dorie J. Gilbert & Ednita M. Wright, *African American Women and HIV/AIDS* (Westport, CT: Praeger Publishers, 2003).

⁹ Ibid.

Concerning the case study design, data collection tools will include, but are not limited to, surveys/questionnaires, focus groups, observations, and key informant interviews.

Additionally, in an effort to provide a wide range of support for not those infected with the HIV virus, but also those who suffer with substance use, all participants meeting the requirements for recruitment (i.e., African Americans in the targeted churches who are substance abusers in recovery and reduce their risk for contracting HIV virus) will participate in an assessment interview prior to receiving peer support services.

This ministry project will collect all required qualitative and quantitative information that will provide results based data. This data will subsequently guide intervention strategies and will be utilized in making project adjustments as needed during the course of this ministry project. This ministry project is committed to utilizing the technical assistance of The Public Health Department of Montgomery County and Wright State University, two key stakeholders in this ministry project. All necessary protocols and forms for collection and reporting of data will be strictly adhered too.

Again, in keeping with the case study design for this ministry project, the initial interview will gather baseline data which includes, but is not limited to, demographics, disability characteristics, substance use, employment history, health status, and community integration. Data gathered via the initial assessment interview will be supplemented with activity logs containing data such as attendance and intensity levels of interventions (e.g., resource connections, attendance at peer leadership trainings, etc.). Moreover, analogous to the program schedule in each of the targeted five African

American churches, follow-up interviews will be conducted at six and twelve months after the initial interview.

With regard to follow-up interviews, initial interviews will obtain information as it relates to contact information (i.e., phone numbers, addresses, and relatives in the area). Only after all previous attempts have been made to conduct the follow-up interview in person, the ministry project team will begin attempts to conduct the aforementioned interviews via telephone. Prior to contacting persons for follow-up via telephone, appropriate permission will already have been obtained in writing at the initial interview. The ministry project team including the author will divide intake interviews, based upon participant's logs. Call logs will be maintained for follow-up. Additionally, calls may include evening and weekend hours.

Data Analysis

The author is pursuing a hunch that once there is a core group of African American churches involved in the process of educating, testing, and providing referrals for HIV/AIDS, in spite of the known opposition to this progressive measure to deal with this subject, other African American churches will follow. However, it is important to take a look at the process, albeit slow of what has occurred over the past several decades in order to see what has, or in this case, has not been done through African American churches to stem the incredible rise of the HIV virus among African Americans.

First recognized early in the 1980s, HIV/AIDS has had devastating consequences. While debates raged concerning the best way to discuss, and medically address

HIV/AIDS, the virus' toll on African Americans continued to grow. According to the U.S. Department of Health and Human Services, as of 1989, less than a decade after the first reports of AIDS, almost 30% of all AIDS patients had contracted the disease through shared needles.¹⁰ The same report indicates that at the end of the 1980s, a primary means of introducing the HIV/AIDS virus into the larger, African American heterosexual population was through sexual contact with drug dealers. Furthermore, most African American children with AIDS were exposed before birth through a drug-using parent, and the number of reported cases of infection nationwide has experienced rapid growth in part because of the number of children infected.

With respect to the two areas of concern here, illicit drugs and HIV/AIDS, the collective African American church activism is often associated with the work of spokespersons such as Rev. Jesse Jackson and organizations such as the National Conference on the Black Family/Community and Crack Cocaine. Using these two as examples, the African American church has typically but not exclusively responded in two ways: (1) slogans, and (2) distribution of information and suggested policy reform. One of the best examples of slogans in Rev. Jackson's "Down with Dope! Up with Hope!" Such slogans were intended to motivate African Americans to take control of their communities and personal dealings. A moral charge was given to adults and young people to own themselves with respect to health.¹¹

The African American church's commitment to dealing with illicit drugs is evident in word and deed. However, the HIV/AIDS epidemic has not been as unilaterally

¹⁰ Pinn, *Black Church in the Post-Civil Rights Era*, 96.

¹¹ Ibid.

addressed. Silence on this issue is often considered appropriate because many African American Christians entertain conspiracy theories related to HIV/AIDS that promote suspicion concerning the disease and the medical industry's research and treatment efforts. According to some accounts, this disease entails a governmentally engineered plot to remove undesirable populations, notably homosexuals, drug users, and racial minorities.¹²

For the African American faith community, the question still centers on the agency of that disease. Why did it appear? Was it sent? Why is there no cure? Why is it uniformly fatal? Why are we seemingly powerless over it? Why does God allow it to continue unchecked? What does it mean? These are questions of theology and theodicy, power, will purpose and providence, even ego. Undoubtedly, these are questions of tremendous complexity; for AIDS presents one of the most complicated interrelationships between potentially conflicting theological constructs: our theologies of disease, faith, and healing; our theologies of lifestyle and personal responsibility; and our theologies of sin and salvation.¹³

The issue is not really one of grand conspiracies but rather a certain perspective on sexual relations in light of scripture and church tradition. Ruby Bailey, a writer for the Detroit Free Press, cuts to the quick:

Two of the three easiest ways to contract HIV are among the most prominent sins in the Bible, extramarital sex and gay sex. African American Churches balked at passing out HIV prevention pamphlets that promote the use of condoms rather than abstinence, they said that following such pamphlets compromised their

¹² Ibid., 98.

¹³ Ibid., 99.

Christian values. Christ, after all, they said, healed the sick, but also said, “Go, and sin no more.”¹⁴

Others question AIDS education because they do not want to give the impressions that they condone premarital sex. One gets a hint of this in the following statement offered by the AME church with respect to HIV/AIDS. In this statement it is argued that the church must “take an uncompromising stand for abstinence from premarital sexual activity, balanced with a commitment to addressing the issues in people’s lives (particularly the lives of our young people) that lead them to report to high risk behavior such as sexual promiscuity.”¹⁵

More progressive and less scripturally literal Christians recognize that African American churches have an obligation to serve their communities and address cases of AIDS, recognizing that the sufferers are individuals, real people, in need of compassion. This does not mean a surrender of moral and ethical commitments, but it does mean an attempt to suspend judgment and to focus on human need. African American churches through the Pennsylvania Council of Churches, for example, echo their perspective: “We ask that public and private resources be appropriated for AIDS prevention, for adequate care for AIDS patients on a continuing basis, and for research toward a cure for the disease.”¹⁶

Concerning the identified process evaluation (i.e., case/qualitative study which will include some qualitative data), an assortment of analytical techniques will be used to

¹⁴ Ruby L. Bailey, “Activist Takes AIDS Prevention Advice to Black Churches,” *Detroit Free Press*, March 22, 1999.

¹⁵ “For We Struggle: A Call to Action,” *The AME Christian Recorder*, October 30, 2000.

¹⁶ Pennsylvania Council Churches, “Statement of Legislative Principles,” <http://www.pachurches.org/html/values.html>.

evaluate the proposed research question. As it relates to key informant interviews, focus groups, observations, and other outcome measures, the identification of common themes may warrant further investigation. Again, this will be analyzed in collaboration with the author, pastors, and participants from the convenient sample group of the five African American churches.

It is anticipated that the proposed program will significantly impact the quality of life of persons seeking HIV/AIDS education, screening, and services for infected persons, including her/his immediate and extended family and/or significant others, as well as, the community through faith-based programs.

Furthermore, the case study is designed to allow this ministry project the opportunity to be replicated and to share experiences and lessons learned experientially. This data will be utilized to guide this ministry project in its faith-based initiatives and to inform African American churches, and those that are impacted by them. This case study will allow for modification of the ministry project design and proposed services approaches, relative to target population, needs, issues, and concerns that have been delineated within this ministry project.

Summary of the Results

As the author had previously alluded to, according to the center for disease control, eight out of every ten persons in the African American community has some contact with the African American church. The African American church has always been a positive force within the African American community for change. However, the

author's dilemma during the course of this ministry project was to enable persons affiliated with the African American churches involved in this project to shed some of their embedded theologies and to become more aggressive in dealing with this pandemic of HIV infections.

Christians learn what faith is all about from countless daily encounters with their Christianity, formal and informal, planned and unplanned. This understanding of faith, disseminated by the church and assimilated by its members in their lives, will be called embedded theology.¹⁷

It is and was the author's aim of this ministry project to demonstrate that African American churches given the proper motivation, resources, and inspiration would not only address the issue of HIV in their churches and their community, but that they would address it sufficiently enough to make a difference. The course of doing so would involve a paradigm shift of near epic proportion. It would involve a move from an embedded theological position of how the church use to respond to issues involving sexuality to a more progressive stance on dealing not only with sexuality, but dealing the consequences of one of the major sin issues in the African American church.

As the author stated previously, embedded theological thinking has served its purpose throughout the ages, however, the author believes that embedded theological thinking has outlived its usefulness. Too many persons have entered into the service of God with biases and presuppositions that do not allow for a fresh thought process to assist in dealing with a wide range of critical issues impacting the African American community and in carrying out the mission of the church. That mission the author

¹⁷ Stone, *Think Theologically*, 13.

believes is clearly stated in Matthew 25:35-36, “For I was hungry and you gave me food; I was thirsty and you gave me drink; I was a stranger and you took me in, I was naked and you clothed me; I was sick and you visited me; I was in prison and you came to me.” Then the righteous will answer Him saying, “Lord, when did we see you hungry and feed you, or thirsty and give you drink? When did we see you a stranger and take you in, or naked and clothe you? Or when did we see you sick, or in prison, and come to you?” And the King will answer and say to them, “Assuredly, I say unto you, inasmuch as you did it to one of the least of these my brethren, you did it to me.”

The author believes that the primary function of the church is to minister to the least of them along with any others who are seeking guidance, strength, and shelter from a cold and heartless world. This would include those who are infected with HIV/AIDS and it is going to require a shift in the way most African American churches have traditionally done things.

The ministry project revealed that there are African American churches that have moved from the embedded theological constructs to more deliberative theology. The selection of African American churches that participated in this ministry project clearly demonstrated that they engaged in the process of carefully reflecting upon embedded theological convictions.

Further investigation has also shown that once embedded theologies become superfluous, the African American church becomes a great agent for change, impacting the African American community in a much more holistic manner. The ultimate goal of this ministry project was a convenient sample of African American churches to be used as satellite operations in the community to provide HIV prevention education and testing,

and serve as links to other community agencies providing HIV, substance abuse, and other health care services. The ministry project objectives have been reached.

Overall, the ministry project has played an important role in reducing stigma associated with HIV those seeking services for HIV. The ministry project has leveraged important community resources by connecting with the African American to use its influence in the African American community ensure that needed services were given to those in need. In particular, this ministry project has started a dialogue within churches around HIV, provided HIV prevention education and testing to a significant number of African American community members, and has begun to establish a faith-based network that will continue to address HIV.

CHAPTER FIVE

THE FIELD EXPERIENCE

Context and Participants

For surely I know the plans I have for you, says the Lord, plans for your welfare and not for harm, to give you a future with hope. Then when you call upon me and come and pray to me, I will hear you. When you search for me, you will find me; if you seek me with all your heart.¹

To understand why the researcher has undertaken such an enormous project is to understand the metamorphosis that the researcher has undergone since arriving at seminary at the graduate level and beyond. Somewhat frightened by all the rumors that the author encountered about seminary, the author pressed on in spite of rumors that seminary kills faith, only for the research to believe initially that the rumors were true. The researcher has not believed those rumors for some time and the researcher's life has been forever changed with respect to what the researcher believes about the Bible and the church, especially the African American church.

Challenges to the researcher's beliefs and thoughts have been transformed to not accept the presuppositions that once were the fiber of the researcher's consciousness. The

¹ Jer. 29:11-13.

researcher no longer accepts any thought or deed without critically reflecting from the author's own social location as to what that thought or deed may mean to the researcher and how it might impact the researcher's community. It is for that reason that the researcher has decided to not accept the status quo as it relates to the condition of African Americans and the response of the African American church to the HIV/AIDS epidemic. The context of the ministry project model was five conveniently selected African American churches located in the Dayton, Ohio community. These churches are affiliated with the Western Union District Baptist Association. This context was chosen because the researcher is pastor of one of the conveniently selected African American churches. In addition the researcher has a professional, as well as a personal commitment, to bringing about a change in the way HIV/AIDS is viewed by the African American church and its members and to help reduce the rapid increase in the rates of infection of the HIV virus.

One of the most essential ways to reduce the increase in the rates of HIV infections is to increase HIV testing. With the 2003 launch of Center for Disease Control's "Advancing HIV Prevention" initiative, the federal government's focus on HIV prevention has placed and increased emphasis on testing. More recently, in September 2006, the CDC issued guidelines recommending that all American adolescents and adults (ages 13-64) be tested for HIV as part of their routine medical care.

There are several reasons for the recent increased focus on testing. The first is that one quarter of the estimated 1.1 million people living with HIV in the United States—180,000 to 280,000 individuals—are unaware of their HIV status and may transmit HIV without knowing that they are putting partners at risk. The CDC has found that once

people learn they are infected with HIV, most will take steps to reduce transmission to sex or drug-using partners. Another reason is the evidence that finding HIV-infected persons who are unaware of their status will facilitate their entry into treatment. To help implement this guidance, the CDC is funding the availability of new rapid HIV test to ensure that those who are tested know their results as soon as possible.²

Compared to other racial groups, more African Americans believe that HIV testing should be treated just like routine screening for other diseases and should be included as part of regular exams (71% of African Americans vs. 63% of Hispanics and 65% of whites) (Kaiser Family Foundation, 2006). A recent CDC study also found that more than two-thirds of HIV-positive African American men having sex with men, hereafter referred to as MSM, were unaware of their infection.

The perception among some African Americans that they are not at risk has been cited as a major factor in the failure to be tested for HIV infection or seek treatment. For example, in a survey of 5,750 MSM who were recruited from venues in seven major urban centers in the United States and then tested for HIV infection, 91% of the African American men in the sample who were HIV positive were not aware that they were infected, compared to 60% of the white, HIV-infected respondents in the survey (XIV International AIDS Conference, 2002). The fact that 39% of African Americans infected with HIV are diagnosed approximately one year before they develop AIDS suggests that timely awareness of infection status may save lives (CDC, 2005).³

² www.nmac.org

³ Ibid.

A national strategy to increase the number of individuals who are tested for HIV infection and admitted to treatment is an important component of a national plan to prevent and ultimately eliminate HIV/AIDS, but testing alone clearly will not be enough and large-scale testing efforts are likely to face a number of challenges.

First, as noted on the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act—the comprehensive federal AIDS treatment program, its testing initiatives are successful in increasing the numbers of individuals who are diagnosed and in need of treatment. There is no certainty that funding for new treatment slots for medications for low-income patients will be available. Thus, wide-scale HIV testing efforts to make African Americans aware of their HIV status could create an ethical dilemma: a large number of people who find out they have HIV may have nowhere to turn for the medical care that can improve chances for survival.

In addition, there is the question of sufficient resources to undertake wide-scale HIV testing: the new CDC strategy calls for increasing of people who know they are infected from 75% to 95%. Achieving this goal would require that an additional 160,000 HIV-positive people learn of their status. If the prevalence in the tested population were 1-3%, then 5.3–16 million people would need to be screened.

The participants for the ministry project model were members of the convenient selection sample of aforementioned churches and the neighborhoods surrounding these churches. The objective of this ministry project model is to produce a model that is easily replicated for African American churches with regards to HIV/AIDS education and resources. Ideally, these services could be coordinated through district associations at

their quarterly, semi-annual, and annual sessions where there are large numbers of participants from churches throughout the state of Ohio.

At the time of this ministry project implementation the convenient selection of African American churches range in size from small to large consisting of memberships from fifty to over one thousand.

Choosing the Context Associates

The context associates and advisors were chosen from within the professional ranks of health care workers and counselors, educators, and prevention specialists whose focus is HIV and substance abuse, as well as those within the ministry venue. Also many members of different African American churches who have identified themselves as Christians working in the area of HIV/AIDS prevention and education were chosen to participate. The author has specifically chosen persons who have demonstrated a commitment to serving those who find themselves on the margins in society.

Each of the associates chosen has met with the author to discuss their interest in working with the author on this ministry project to discuss their role. Expectations were clearly delineated and all of the context associates agreed to assist the researcher on this ministry project. The importance of this project was embraced by the context associates as they informed by the researcher of the intent to shift the paradigm from complacency to action.

In our first session as a project group the gravity of the situation within the African American faith community was explained in great detail. The project team along

with the researcher was tasked with finding a strategy that would greatly impact the perception of HIV/AIDS on the African American faith community and the lack of a concerted response from the African American churches. To narrow our project scope, a swot (strengths, weaknesses, opportunities, and threats) analysis of the current state of HIV/AIDS health related ministries was performed on the African American churches of the Western Union District Association in the Dayton community.

A critical first step in this process was recognizing that churches can play a pivotal role in promoting the health and wellness of the African American community through their ability to mobilize awareness, distribute critical information, and support healthy choices. Something must be done to shift the paradigm from a sense of apathy to a call to action. This project team of associates under the direction of the author intends to mobilize a coalition of concerned individuals along with African American churches and other concerned agencies to make a difference. The project team of associates and the author conducted a needs assessment to determine direction, resources, and a strategy to approach this ministry project. After concluding this process, it was time to begin the task of choosing the test groups.

Choosing the Test Group

Having already identified the project participants, the field had to be narrowed to the African American churches from the larger District Baptist Association to the aforementioned convenient selection of African American churches from within the parent body. The project team and the researcher decided to implement this ministry

project with a core group of five African American Churches from the Dayton community as a test group. The participants would be African American, eighteen years of age and older for the purposes of this ministry project study. The pastors of these five African American churches were telephoned by the researcher to set up a meeting to request their participation in this project.

The pastors were informed of the project requirements and were asked for permission for their churches to be involved with this project. All five pastors agreed and they were asked by the researcher to set up and be present at focus groups to view the content of the material to be presented. Some of the educational material is graphic and the researcher wanted to get buy-in from the pastors and he did not want to shock any of the participants by not affording them the opportunity to pre-screen the material. Presentations were conducted with the pastors and representatives selected by the pastors focusing on HIV/AIDS facts, the impact of HIV/AIDS on African Americans, the African American churches response to the epidemic in the African American community. These presentations were focused on the African American church's role and responsibilities in creating solutions to the HIV crisis in their community. After viewing the material, all five pastors and their respective congregational representatives were even more eager than they had correspond to the author about getting involved in this ministry project and wanting to help transform the African American church in the Dayton, Ohio community and beyond.

The result of this effort was that several day-long workshops entitled, "Affirming A Future With Hope (HIV & Substance Abuse Prevention for African American Communities of Faith)" were held. The aforementioned curriculum was provided by the

Centers for Disease Control (CDC). This curriculum was developed specifically for the African American faith community with an aim toward a personal relationship with God and utilizes faith-based narratives, spiritual principles, and personal experience to address HIV prevention (Centers for Disease Control and Prevention & Interdenominational Theological Center, 2001).

Each session began with an orientation by the researcher, followed by insights from the pastor of the church. The researcher petitioned for and received from each pastor an endorsement of the project, as well as the pastor being first in line to receive and HIV screening test. The expectations from the test group were in a manner to solicit their complete cooperation and honesty. This was accomplished by giving the group the procedures for conducting HIV screening and sharing with the group the confidential nature of each test to put any trepidation at ease. The researcher then explained the necessity of the pre- and post-test.

Implementation of the Methodology

Data Collection

The author has incorporated a team of professional action researchers, as well as members of other community organizations seeking to improve their situation that is necessary to fulfill the requirements of action research, a qualitative method. The action research accomplished its intended objective of promoting broad participation in this ministry project and appeared to satisfy the stakeholders involved in this ministry project.

The pre- and post-tests were executed prior to the participants from the convenient selection of African American churches receiving any educational information about HIV/AIDS. The post-test was executed after the educational sessions had been conducted with the participants. To ensure the fidelity of this research, any participants who arrived late for the educational session was not given the pre- or the post-test.

In order to acquire a base-line of knowledge for the participants, a pre-test survey was administered. Following the pre-test, participants were also given a risk assessment to determine vulnerability based on facts and not innuendo or hearsay (See Appendix B for the pre-test survey and risk assessment). After receiving the pre-test and risk assessment surveys, the educational sessions were started.

Analysis of Data

The HIV/AIDS epidemic continues to be a significant public health challenge both nationally and locally. The impact of this challenge is felt most strongly among minority communities, particularly African Americans, who have been disproportionately affected by HIV since the beginning of the epidemic. This trend is no different in Montgomery County, Ohio where the five selected African American churches and African Americans account for 419 HIV cases per every 100,000 people (rate among Caucasians is 109 per 100,000).

The chronic, disproportionate impact of HIV/AIDS on African Americans is a result of the complex interaction between multiple risk factors. Individual behaviors such as substance use and unsafe sexual practices interact with more complex social realities

like poverty, racism, unequal access to healthcare, and limited community capacity to help promote HIV transmission among African Americans (Adimora & Schoenbach, 2005; Aral, Padian, & Holmes, 2005; Cargill & Stone, 2005; Farley, 2006; Sumartojo, 2000). Solutions to these issues are not easy and require the commitment on communities to effectively address them. Communities, including formal organizations, as well as informal groups and local citizens, are experts in their own realities and know the best ways to address HIV using their collective strengths. Based on this understanding the ministry project endeavors to form coalitions of African American churches to assist in developing solutions to the growing HIV epidemic in minority communities, particularly the African American community.

To move this effort forward, this ministry project teamed with concerned citizens, professional health care workers, counselors, and African American churches to impact the community in an effort to create more awareness, access to treatment and education with regard to the HIV/AIDS epidemic, and the issues that have created an opportunity for this disease to be spread. Since its inception, this ministry project has undertaken a variety of activities to address HIV in the African American community. Overall, the biggest strength of the project has been the participation of local agencies and citizens in devising solutions to this issue. Partners include the Combined Health District of Montgomery County; three substance abuse treatment agencies: Center for Alcoholism and Drug Addiction Services (CADAS), Consumer Advocacy Model (CAM), and Project CURE; AIDS Resource Center Ohio; Wright State University's Substance Abuse Resources and Disability Issues program; the faith-based community, and; Citizens Against Death, a consumer group dedicated to educating the local community about HIV.

Collectively this group has diligently worked to build sustainable solutions to the local HIV epidemic; solutions that target not just individual behavior, but the larger community issues that put African Americans at increased risk for HIV infection.

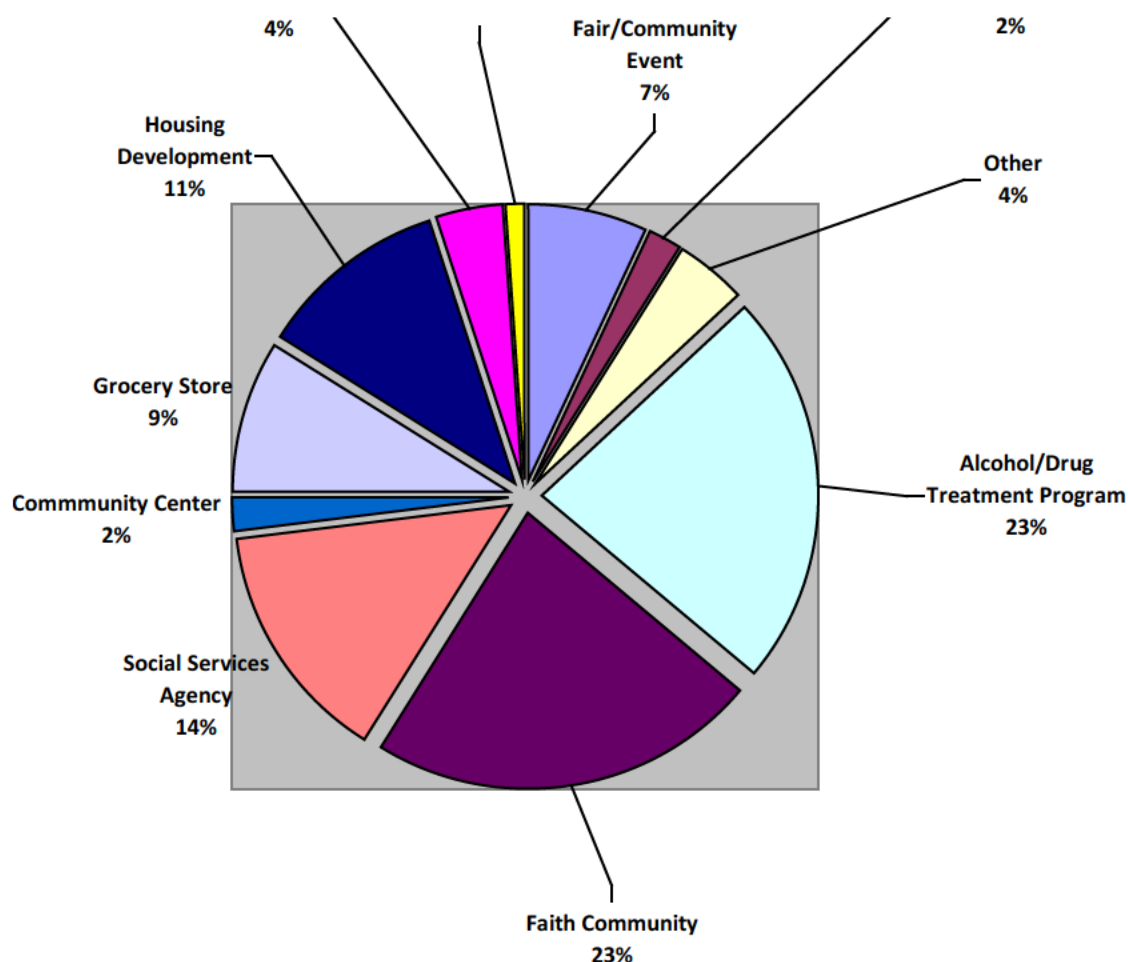
Mobile HIV Testing

Prior to this coalition of agencies coming together, HIV testing had only been available from stationary testing sites throughout Montgomery County. Results from a community assessment conducted by this health-care coalition revealed, however, these services were not reaching those most at risk for HIV infection. Specifically, HIV testing data from the community assessment revealed that local HIV testing numbers had decreased. In addition, community stakeholders noted that high-risk populations were not accessing HIV services at traditional testing sites and consumers described significant barriers to getting tested for HIV including transportation issues, lack of time to get tested, and the stigma associated with going to a known community HIV testing site.

The Public Health Mobile Unit is specifically designed to increase community access to health screening services by providing free, confidential HIV testing and counseling, as well as blood pressure, blood glucose, and Prostate Specific Antigen screenings to targeted areas in the community. Free educational materials on various health issues and safer sex kits are also available. For persons who elect to have an HIV test, pre-test counseling is provided immediately to assess client risk behaviors, readiness for HIV testing, and support systems in the event of a positive result. Counselors are certified in Counseling Testing and Referral (CTR) and Partner Testing and Referral

Services (PTRS), following the CDC's recommendations for HIV testing. After pre-test counseling, individuals complete OraQuick Rapid Advance HIV ½ Antibody Testing (OraSure Technologies, Inc.). While waiting for test results, the counselor talks to the person about personal risks and harm reduction strategies, and develops a risk reduction plan. Post-test counseling occurs once test results are ready. If the test is negative, the counselor reviews the risk reduction plan and reinforces risk reduction strategies. If the test is a preliminary positive, the counselor conducts a confirmatory blood draw, processes the positive result with the individual, and conducts daily follow-ups until confirmatory results are received by the Combined Health District. Once confirmatory results are in, the counselor re-contacts the individual and arranges a time to provide the confirmatory result. For persons whose confirmatory test comes back positive, the counselor processes the results again, provides information on Ryan White funding, and immediately refers the person to medical care.

Since the Public Health Mobile Unit began providing services in December 2004, it has been scheduled to service different parts of the community for events at least twice each week, including weekends. Targeted sites include substance abuse treatment programs, churches, and community health fairs (see Table 1 for an overview of PHMU testing sites). To date, the majority of van events (60%) have occurred at substance abuse treatment programs, churches, and social services agencies (e.g., homeless shelter, food bank).

Table 1: Overview of Public Health Mobile Unit Testing Sites

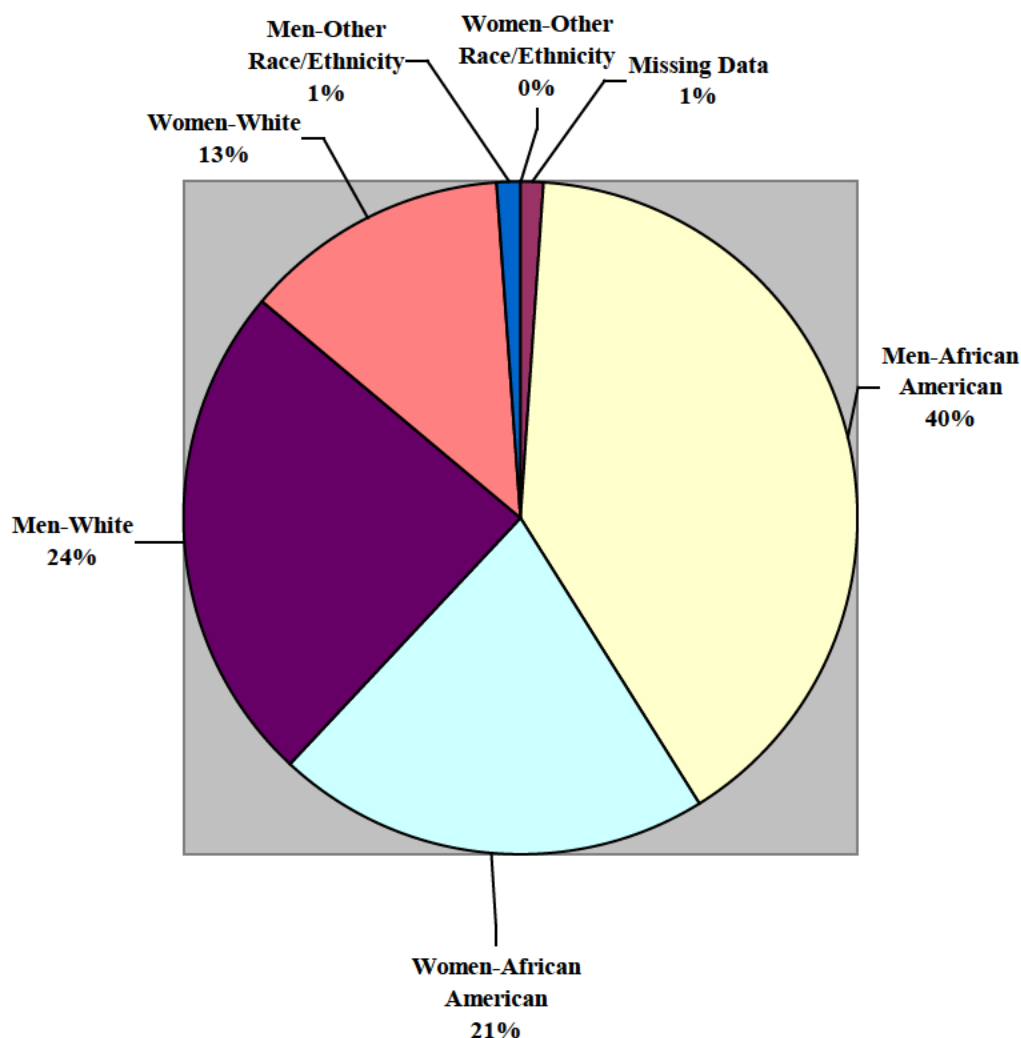
In terms of community impact, the PHMU has increased the number of HIV tests conducted in Montgomery County, Ohio by 33% between 2004 and 2006. During this time, the only major change in HIV testing strategies in the County was the introduction of the PHMU. Furthermore, the PHMU conducted one fifth of all HIV tests in the County in both 2005 and 2006 and identified 7.8% of all HIV positive individuals during this same period. These data demonstrate the ability of the PHMU to not only improve the reach of HIV testing within the County, but to also identify HIV positives.

Faith-Based Outreach

Outreach has included both face-to-face and group outreach activities focusing on the provision of HIV education and referrals for HIV testing and substance abuse treatment. This ministry project has included the faith community utilizing the mobile unit because: 1) the church has a strong, local presence in the African American community, and 2) findings from a local survey of 73 churches revealed over half had wellness ministries, although none of the ministries addressed HIV/AIDS or other infectious diseases. Because of the church's influence in the community and its active involvement in health-related issues, the ministry project devised a faith-based HIV outreach initiative to: 1) increase recognition among church leaders of HIV as a critical health issue facing the African American community, and provide leaders with specific spiritual approaches for addressing this within their churches and the larger community; 2) provide an HIV prevention workshop within local churches to expand HIV/AIDS education and testing, and; 3) establish and expand wellness ministries within churches.

Overall, twenty two churches participated in the faith-based HIV prevention workshop between June 2005 and October 2006. These workshops touched 973 people, with 29% of participants (229) getting tested for HIV (no previously undiagnosed HIV was detected). In addition, the workshops resulted in six of the participating churches incorporating HIV/AIDS information into their existing wellness ministries. The greatest success of this faith-based HIV outreach initiative is the establishment of the Mt. Olive Drop-In-Center as a community outreach center and permanent HIV testing site for the Public Health Mobile Unit. The Drop-In-Center was established at Mt. Olive Baptist

Church, a historically African American church located in West Dayton in a neighborhood that is predominately low income and experiences high crime rates due to substance abuse related issues. The Drop-In-Center operates two days a week for people to access services including HIV testing and counseling on the PHMU, HIV and hepatitis education, support groups, and referrals to job training, GED classes, substance abuse assessment and treatment, and HIV medical treatment. The church also has an established food and clothing pantry for low income families, as well as re-entry and homeless persons. Outreach workers canvass the neighborhood on the days the Drop-In-Center is open providing HIV education and encouraging individuals to come to the church for an HIV test. Since the church became a HIV testing site in January 2007, 346 tests have been conducted and three positives (1 male, 2 females) identified (see Table 2 for a demographic overview of individuals tested).

Table 2: Demographic Overview of HIV Testing Services Provided at Mt. Olive

Mt. Olive Baptist Church has historically been involved with social change issues in the minority community. Through its collaboration with this ministry project, Mt. Olive expands its role in promoting the health and wellness of minority communities with the establishment of a church-based HIV testing site, allowing high-risk individuals the opportunity to be tested within their own community and minimizing the stigma associated with testing services at traditional healthcare facilities.

Future Directions

This ministry project along with its collaborative partners has sought additional resources to continue and expand the efforts of the Public Health Mobile Unit and Mt. Olive Baptist Church. Two federally funded projects that began in 2006 will provide the initial funding needed to continue these HIV testing initiatives in the African American community. With the success of the Mt. Olive testing site in conducting HIV tests and identifying positives, outreach strategies will continue to be refined to ensure high-risk individuals in this neighborhood are aware of HIV testing and other support services at the church. Furthermore, other churches in predominately African American communities will be approached about their interest in providing similar satellite operations in the County. The success of the Public Health Mobile Unit and Mt. Olive Baptist Church highlight an emerging need to provide HIV-related services in non-traditional settings with immediate access to populations most at risk for HIV infection. This ministry project will continue to monitor the impact of these HIV testing initiatives as they improve this community's capacity to address HIV infection among African Americans. The researcher believes that a successful model has been created and is easily replicable for any church or faith entity.

CHAPTER SIX

REFLECTIONS, SUMMARY, AND CONCLUSIONS

Reflections

Upon reflection, the author is forced to reconsider what has brought him to this point in his life to feel the compulsion to do this ministry project. Was it a calling from God, was it the author's work as a police officer in one of the toughest cities in the United States where he experienced marginalized and disenfranchised persons on a routine basis, or was it lost of two beloved family members to AIDS-related deaths. Whatever the reason(s), the author is determined to make a quantifiable difference with this ministry project. Having personally experienced the devastation of what this virus can do to one's physical body and the emotional trauma on families, the author knows firsthand some of the preventable measures that can and should be taken to prevent such devastation. When the AIDS epidemic first casualties were being realized, the author remembers how when responding to the hospital to take police reports and how the stigma was so prevalent surrounding those persons infected with the HIV virus. The quarantine rooms, the whispers of person passing by, and the overt suggestions that anyone with the HIV virus was somehow rightly being judged by God.

I must confess that some of the viewpoints expressed here were also shared by the author. I must also confess that the author's viewpoints were made out of fear of the unknown and ignorance. Since the lost of family members to the HIV virus and awakening in the author's spirit as to the will of God, many things have changed in the author's life with respect to how persons with the HIV virus are personally viewed by the author. Part of that awakening for the author was the realization of the need for African American churches to come to the forefront in the war against HIV/AIDS. The author not only served on the front lines of dealing with the devastation of HIV/AIDS, but also has spent the last six years professionally working in the area of HIV/AIDS and substance abuse with minority populations.

The author's vision for this ministry project was solidified during this time. This work gave the author the opportunity to gather much needed expertise on the subject of HIV/AIDS, credentials, and experienced that would prove invaluable during this ministry project. One of the major considerations for the author's reflection is the fact that has an organizational affiliate; the Baptist organizational structure of the Western Union District Association mirrors that of the National Baptist USA, Inc. It was extremely difficult to penetrate the powers to be and introduced an issue that not many pastors wanted to deal with. The fact that there are no ministries dealing with infectious diseases, nor a central hub of information available to thousands of people and their families who may need it posed a significant problem for this ministry project. The fact notwithstanding that this project was not warmly received by many of the Pastors made the task even more formidable.

The author's initial meetings with substantial numbers of pastors affiliated with the larger associational body were largely unsuccessful. Many of the pastors either believed in a conspiracy theory against the African American community or believed that God's wrath was the reason for HIV virus. Needless to say this kind of thinking and many of these attitudes perplexed the author beyond his ability to comprehend. This was not the first time that the author has dealt with this kind of thinking. The author's time spent as an associate minister in a traditional setting has prepared the author well in terms of his own resiliency to find alternative methods to be successful. Having been met with such a volume unanticipated resistant the author know that this ministry project was far too critical for the African American church and community to be defeated and so another strategy became necessary.

The author learned that not all of the pastors felt the same and that there were some willing, if not able to accept the challenge to stand and make a difference in the fight against HIV/AIDS. Hence, the author moved forward with the five selected churches who agreed to participate in this ministry project. The position taken by many of the African American Pastors in many African American churches speaks to the greater issue of the African American churches silence on the issue of HIV/AIDS and what the author believes is complicit behavior in the spread of the disease. The author does recognize the gravity of this statement, however, based on incontrovertible facts that the African American church is still the most powerful institution in the African American community; it must use its power and influence to make a difference in this war on HIV/AIDS. Thus far the African American church with a few exceptions has not done so.

The author learned throughout this process that many times projects such as these, that are geared to hopefully reach massive numbers of people, one can become discouraged when the appearance is that we will not be able to accomplish very lofty goals initially. The author recognized something that he always says, but often time forgets and that is God plus one is a majority and no matter what the adversity we face we must be willing to trust God and move forward. Necessity being the mother of inventions, the author understood the need to be persistent throughout this ministry project, no matter what obstacles he faced. While the author clearly understood that there are not enough African American churches speaking to the issue of HIV/AIDS, the author also unmistakably understood that he had an opportunity to increase the number of African American churches that were willing to speak on the issue of HIV/AIDS and it was an opportunity that must be seized.

The author had to continually grasp the pandemic of HIV/AIDS infections that was wreaking havoc in African American communities. Staying focused on the objectives of this ministry project and presenting written documentations of biblical, historical and theological foundations was necessary to the success of this ministry project. This information provided examples of why the church is so prominent in the African American community, as well as why the African American church cannot and must not remain silent on the issue of HIV/AIDS virus. Acquired Immunodeficiency Syndrome is being referred to as the number one public health issue of our time.

In addition to the aforementioned goals, the author also wants to establish HIV/AIDS related ministries in selected African American churches, provide the necessary leadership and resources necessary to fulfill these objectives. This ministry

project team was also equipped through their collective expertise to prepare African American churches to be able to educate, test, and refer those persons infected and affected congregational members, their families, and members of their immediate communities to the appropriate resources within their communities for services related to HIV/AIDS associated issues. With this agenda in mind the ministry project proceeded to create a model for ministry that could easily be replicated by any church that would be so inclined to do so.

Through the aforesaid process the author was able to shed new insights to provide to the ministry project participants with a greater understanding about HIV/AIDS. This new information seems to astonish some of the participants while at the same time dispelling many myths about how the HIV virus is acquired. Many of the participants preconceived notions about HIV/AIDS were erroneous and those misconceptions were corrected. Some of those notions were the usual myths that the author frequently has to deal with during educational sessions about the HIV virus. One of the most compelling moments came during a plenary session with a speaker whom the project participants did not know was HIV positive. This particular speaker was chosen by the author and has been one of the author has used on numerous occasions because of her advocacy on behalf of persons infected with the HIV virus. The speaker identifies herself as Christian, she is articulate, mild mannered, and looks like the preverbal girl next door.

The speaker delivers her presentation with such passion that the program participants are absolutely captivated. She literally has them eating out of her hands and then she drops a bombshell. She shares with the program participants that she is HIV positive and has been so for over a decade. She informs them about her background. How

she was not what one would think when they think about someone with the HIV virus. She spoke having only two sexual encounters during her time spent in college and no more. One of those persons was positive with the HIV virus and passed it on to her. She was not aware of her status for almost a year and after substantial weight loss, she finally went in for a check-up and after several failed attempts to diagnose her, someone suggested an HIV test. The results were positive for the HIV virus.

Our presenter than spoke of what she feared the most, she utterly shocked the project participants when she shared that her greatest fear was them. While many were afraid of persons with the HIV virus, they were shocked to know that persons with the virus were terrified of much human contact. She explained that if she came into contact with anyone who was suffering from a cold, that if they transferred the germs to her, they could kill her. At the end of the plenary session, I have never witnessed such an outpouring of love in all my life for someone infected with the HIV virus. These program participants had truly been transformed with a new understanding of how the HIV/AIDS virus is transmitted.

The fact that our presenter identified herself as Christian made the author's job a lot easier for the project participants to realize that Christians can get the HIV virus just as well as anyone else, and the presenter also spoke to the need of spiritual intervention by the church. This particular strategy is one echoed by the Affirming a Future with Hope curriculum which was taught to the Pastors of the five selected African American churches and the program participants. The Affirming a Future with Hope curriculum emphasized the pandemic conditions of African Americans and spoke to the need of the

African American churches, a stalwart of faith, education, and community activism for more than 200 years to get involved.

Part of the stigma associated with HIV/AIDS is keeping many of the African American churches from getting involved. It gives the impression that African American churches in large measure are afraid of being accused of harboring persons who are sexually promiscuous and sinful. What the author has observed from discussions during the course of this project is that when it comes to sin, what has been called illegal sex is usually at the top of many lists. Illegal sex defined by some of the project participants has been described as any sex between unmarried. Stigma and ignorance are enemies of this dreadful disease and it is unfortunate that the African American church has done little to eradicate the stigma, nor educate herself on the HIV virus. When it comes to the response of the African American church, it has to be measured by the reported response of Jesus, as you have done to the least of these; you have also done unto me.

Let me reiterate that the African American church is the most powerful institution in the African American community. The church is a physical edifice, but we must also remember that the church is also its people. The African American church is an historic institution ideally positioned to change the course of the HIV/AIDS pandemic. The church, whether a small wooden frame, stained-glass cathedral. The church is the place where people come to encounter God, and in the process, experience some degree of spiritual transformation. The church is also the place where the fundamental lessons of morality, or right living, are taught, practiced, nurtured. From its teachings on the Ten Commandments to the Lord's Prayer to the Beatitudes to the Parousia, the church embodies that which right trustworthy. It is through the teachings and practices of the

church that people are invited to cultivate a personal relationship with God that guides them away from attitudes and behaviors that endanger their spiritual and physical health and toward those that promote it. This relationship, like a garden, must be continually tended and nourished in order to grow. Spiritual growth is what supports individuals in developing attitudes and behaviors that sustain them in positive, life-affirming standards for daily living.

This is why more faith leaders must become actively engaged in the battle against AIDS. People in the African American church need to know what HIV/AIDS is and who is at risk for contracting it. They need to know how the virus is acquired, transmitted, and prevented. They need to be able to apply principles of “right living” to all aspects of their lives. They must know the larger context into which HIV/AIDS fits, a context that encompasses not only the dimensions of mind, body, and spirit, but also the economic, physical, and psychological factors that militate against risk-reducing behaviors.

The African American church must not abandon those who are infected and affected with the HIV virus or AIDS. The HIV/AIDS virus is no longer a death sentence and those persons impacted by this disease must still be given the opportunity to receive Jesus Christ as their personal savior. In order for this to occur, the African American church must create an atmosphere of receptivity where those infected and affected persons will feel free to come and seek the guidance of the church. This tremendous opportunity to reach out and bring in hurting persons must not be overlooked. After all the church is still a place of healing and wholeness.

One of the research consistencies of this ministry project has shown that once the selected five African American churches became involved with the education of

HIV/AIDS, substance abuse related issues, their knowledge and compassion increased considerably. If the African American church would become a who-so-ever church and embrace all those that came through their doors, just imagine what could happen. There is a page out of the author's own playbook that is applicable here. When our youngest son was 13 years-old, he went through what most new teenagers go through trying to find themselves. He was constantly having trouble adjusting to all the issues that come with being 13. The author tried a variety of measures to correct the behavior and nothing worked. The author then shared with his son that the next time he goes into trouble that he would deal with him in a more aggressive manner.

Well, the threat by the author did not work and his son got into trouble again. That evening, while the author was attempting to discipline his son, he was convicted by God. God spoke to the author and challenged him as to why he had not created an atmosphere that was conducive for his son to disclose his problems. The author then realizes that it was easier for his son to talk to gang members, other adults, anybody but the author. The author then apologized to his son and told him that no matter what happened in his life that the author was prepared to love him through it. It was a novel concept, certainly not original, but novel. Love them through it. That's what the African American church must learn to do. The African American church must learn to love people through their sickness, through their disease, through their broken relationships. Love people through it.

The African American churches must get involved on the front end of the HIV/AIDS virus. With African American females being the fastest rising demographic in terms of those persons contracting the HIV virus and the fact notwithstanding that

African American females are the majority presence in the African American church, something must be done immediately. Getting involved on the front end means that more must be done in terms of prevention.

Prevention means keeping something from happening, and is a normal response to the threat of danger. This definition is reminiscent of that tried and true maxim: an ounce of prevention is worth a pound of cure. If the African American church develops a strategy of prevention, then that strategy in the process of its development would compel the church to ask that all important question of how can I prevent the HIV virus from spreading. Prevention is a reoccurring Biblical theme and when the African American church applies this Bible theme to its prevention work, a lot of lives will be saved.

Recent studies have indicated number of AIDS cases in the US declining but the increasing rate of HIV infections in the general population indicates that more, not fewer, prevention strategies are needed. The fact is that prevention works. Prevention efforts have resulted in thousands of individuals changing their behavior from high-risk to low- or no-risk. Many persons, however, are not connected to a network through which they can receive appropriate prevention messages; others have access to prevention information, but, for many reasons, are not applying that information to their lives. The vehicle for change as it relates to prevention can and should be the African American church.

When a person contracts the HIV virus or AIDS, this presents a plethora of issues that must be dealt with. These issues are, but not limited to, housing, food, monetary assistance, clothing, counseling, and perhaps substance abuse treatment. For many of these issues the African American church is uniquely qualified to deal with. Much of the

needed assistance is already being provided in many of our clothes. One of the main problems that this ministry project endeavors to address is that the services provided in countless instances do not include persons suffering from HIV/AIDS. After being diagnosed with the HIV virus, many of the persons affiliated with the African American church have no place to turn for help. They are unable to connect to resources being already provided in their communities because the church is unaware that these resources exist. Through the Ryan White Care Act the government has provided resources to the tune of \$147 million dollars to cities for HIV/AIDS care. Each year, more than 53,000 individuals receive care under the Ryan White Program. The author wonders how many have been referred by African American churches.

Summary of Findings

What the research has showed in many instances is that when the African American churches are involved with the care of persons affected with HIV/AIDS, those persons are more likely to respond to the treatment. The non-judgmental support provided by one of the most trusted institution in the African American community tends to make a substantial difference in the way people respond to their diagnosis. African American persons who have self-disclosed their HIV status who are affiliated with African American churches fare much better than those persons who show no such affiliation.

Education of the clergy and congregation has made a tremendous impact on the way the African American churches received and treat those African American persons

affected with the HIV/AIDS virus. Prior to being educated on the subject of HIV/AIDS and substance abuse, many of the churches involved in this ministry project had differing views on how persons with the HIV/AIDS virus should be treated. There has definitely been a paradigm shift in the thinking of some of the leaders of these congregations, as well as the congregations themselves.

Conclusion

Oftentimes the African American church is too focused on meeting spiritual needs to the exclusion and exception of the physical needs of the individual. There seems to be an unhealthy pattern of too much of one and not enough of another. African American churches have to become better equipped to deal with the complexity of African American persons infected with HIV/AIDS. In addition to battling the enormous amount of health issues associated with this devastating disease, there is also the issue of the stigma associated with these persons. The issue of stigma alone, in many instances is enough to keep African Americans from seeking assistance from anywhere, let alone the church. What is needed are comprehensive holistic services that help people reassemble their lives after being diagnosed with such overwhelming news as having the HIV virus. Access to treatment is only the tip of the iceberg. Some individuals are so severely traumatized by poverty, family issues, social, and spiritual development that any changes requires intensive interventions.

African American churches need to do a much better job of collaborating on needed services and a whole lot less time on the traditional fellowships that do little to

serve the congregation and the community. Moving people from a “hopeless” to a “hopeful” state requires long-term relationship-based services that include spirituality. Moving an individual through this process of spiritual change is related to behavioral changes that they experience. The movement from hopeless to hopeful is much more than simple access to services, but requires reorganization of that individual’s relationship with his or her environment. A big part is that environment, whether they accept it or not, is the African American churches.

The author uncovered many programs that are willing and able to assist persons affected with HIV/AIDS. However, the author did not discover many African Americans who are willing to do the same. Whether the issues are denomination, doctrinal, or theological is unknown, but the one thing that is crystal-clear is that African Americans are disproportionately impacted by the HIV/AIDS virus and the African American churches are doing very little in terms of a solution to eradicate the problem.

The critical component of this ministry project was to produce a model for ministry that is easy to replicate. The author believes that we have created such a ministry model. This ministry model offers a wide range of comprehensive, culturally sensitive services including but not limited to, education on HIV/AIDS, substance abuse for clergy and congregations, HIV rapid testing, evaluation, counseling food, collaborations, and resource referrals. This ministry project provides an example of how collaborative services can be provided to better serve African American persons infected with HIV/AIDS virus and those persons suffering from the effects substance abuse. It is the prayer of this author that this ministry model will be taken advantage and use for the greater good of the African American churches and community.

APPENDIX A

THE TYPICAL TYPE OF FLYER DISTRIBUTED TO THE CHURCH CONGREGATION AND THE SURROUNDING COMMUNITY PRIOR TO THE EVENT

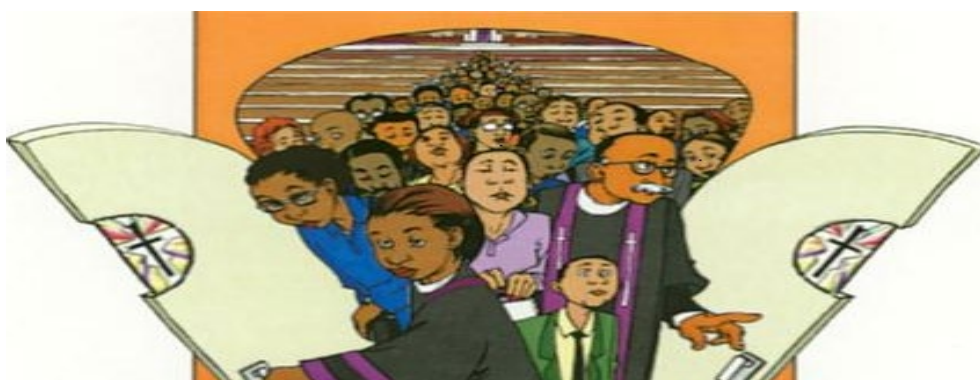
APPENDIX A

Greater St. John Missionary Baptist Church
(Pastor Lloyd D. Hayes)

Friendship Baptist Missionary
(Reverend Henry Colvin)

Good Samaritan Baptist Church
(Reverend Kerney Mosby)

Affirming a Future with Hope
Health Awareness and Leadership Seminar



- ★ Establishing Wellness Ministries
- ★ HIV and the African American Community
 - ★ Women and HIV
 - ★ Free Health Screenings

Lunch Served

Open to the Public

Saturday September 24th 2006
11:00am to 1:00pm

Greater St. John Missionary Baptist Church
4200 Germantown
Dayton, OH

APPENDIX B

HIV/AIDS PREVENTION 101 PRE-TEST SURVEY, RISK ASSESSMENT, AND POST-TEST SURVEY

APPENDIX B

HIV/AIDS Prevention 101 Pre-Test Survey

Please circle how much you agree or disagree with the following statements. Please circle only one answer for each question.

1. You believe that you could become exposed to the HIV/AIDS virus.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
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2. You think that you really could get HIV/AIDS.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
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3. You want to make some changes now that will reduce your HIV/AIDS risks.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
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4. You need help in dealing with your drug use.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
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5. You need help to change some of your sex activities.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
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6. You get tired of the problems caused by drugs.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
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7. You are going to change your drug use activities to avoid HIV/AIDS.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
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8. You are going to change your sex activities to avoid HIV/AIDS.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
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9. You already know what you must do to reduce your HIV/AIDS risks.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
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Questions 1-11 come from the TCU HIV/AIDS Risk Assessment

10. You feel sure of yourself in controlling your risky drug use activities.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
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11. You feel sure of yourself in controlling your risky sex activities.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
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12. I know where to go to get tested for HIV.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
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13. There are more good things about getting tested for HIV than bad things.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
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14. I am ready to get tested for HIV.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
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STOP HERE!

**THANK YOU! YOU HAVE REACHED THE END OF THE PRE-TEST
SURVEY.**

PLEASE WAIT UNTIL THE INSTRUCTOR TELLS YOU TO CONTINUE.

Risk Assessment Questionnaire

1. Have you shared needles to inject drugs?
Yes _____ No _____
2. Have you had unprotected vaginal sex, such as intercourse without a condom?
Yes _____ No _____
3. Have you had unprotected oral sex, without a condom, dental dam or latex barrier?
Yes _____ No _____
4. Have you had unprotected anal sex without a condom?
Yes _____ No _____
5. Have you had a sexually transmitted disease (STD)?
Yes _____ No _____
6. Have you had an unplanned pregnancy?
Yes _____ No _____
7. Have you used someone else's works that weren't cleaned with bleach?
Yes _____ No _____
8. Have you had unprotected vaginal intercourse, oral sex, or anal sex without using a condom, dental dam, or latex barrier with a partner whose sexual history you did not know?
Yes _____ No _____
9. Have you had unprotected sexual intercourse while you were high on a substance?
Yes _____ No _____
10. Have you had unprotected vaginal sex with a person who refused to wear a condom?
Yes _____ No _____

HIV Risk Score: Add the number of YES responses and record here _____

STOP HERE. You have finished the Risk Assessment. Please wait until the instructor tells you to continue.

HIV/AIDS Prevention 101
Post-Test Survey

Please circle how much you agree or disagree with the following statements. Please circle only one answer for each question.

1. You believe that you could become exposed to the HIV/AIDS virus.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
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2. You think that you really could get HIV/AIDS.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
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3. You want to make some changes now that will reduce your HIV/AIDS risks.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
---------------------------	---------------------------	---------------	------------------------	---------------------

4. You need help in dealing with your drug use.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
---------------------------	---------------------------	---------------	------------------------	---------------------

5. You need help to change some of your sex activities.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
---------------------------	---------------------------	---------------	------------------------	---------------------

6. You get tired of the problems caused by drugs.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
---------------------------	---------------------------	---------------	------------------------	---------------------

7. You are going to change your drug use activities to avoid HIV/AIDS.

Disagree strongly 0	Disagree somewhat 1	Not sure 2	Agree somewhat 3	Agree strongly 4
---------------------------	---------------------------	---------------	------------------------	---------------------

8. You are going to change your sex activities to avoid HIV/AIDS.

Disagree strongly	Disagree somewhat	Not sure	Agree somewhat	Agree strongly
0	1	2	3	4

9. You already know what you must do to reduce your HIV/AIDS risks.

Disagree strongly	Disagree somewhat	Not sure	Agree somewhat	Agree strongly
0	1	2	3	4

10. You feel sure of yourself in controlling your risky drug use activities.

Disagree strongly	Disagree somewhat	Not sure	Agree somewhat	Agree strongly
0	1	2	3	4

Questions 1-11 come from the TCU HIV/AIDS Risk Assessment

11. You feel sure of yourself in controlling your risky sex activities.

Disagree strongly	Disagree somewhat	Not sure	Agree somewhat	Agree strongly
0	1	2	3	4

12. I know where to go to get tested for HIV.

Disagree strongly	Disagree somewhat	Not sure	Agree somewhat	Agree strongly
0	1	2	3	4

13. There are more good things about getting tested for HIV than bad things.

Disagree strongly	Disagree somewhat	Not sure	Agree somewhat	Agree strongly
0	1	2	3	4

14. I am ready to get tested for HIV.

Disagree strongly	Disagree somewhat	Not sure	Agree somewhat	Agree strongly
0	1	2	3	4

15. How helpful was this workshop in explaining how people get HIV/AIDS?

Not helpful at all	A little helpful	Not sure	Somewhat helpful	Very helpful
0	1	2	3	4

16. How helpful was this workshop in giving you ways to reduce your risk of getting HIV/AIDS?

Not helpful at all	A little helpful	Not sure	Somewhat helpful	Very helpful
0	1	2	3	4

17. Overall, how would you rate the quality of this workshop?

Excellent	Very good	Good	Fair	Poor
0	1	2	3	4

18. Are you a participant in the Brothers to Brothers/Sisters to Sisters project?

No (0) Yes (1) Don't Know (7)

19. What is your gender?

Male (1) Female (2) Transgender (3) Other (Please describe)
(4) _____

20. What is your race/ethnicity?

Other (Please describe)(0)
 Black or African American.....(1)
 Asian.....(2)
 American Indian.....(3)
 Native Hawaiian or other Pacific Islander.....(4)
 Alaska Native.....(5)
 White.....(6)
 Hispanic/Latino.....(7)

21. What is your age? _____

22. Have you ever been tested for HIV before?

No (0) Yes (1) Don't Know (7)

**THANK YOU! YOU HAVE REACHED THE END OF THE POST-TEST
SURVEY.**

APPENDIX C

EDUCATATING WOMEN TO REDUCE THE RISK OF GETTING HIV/AIDS THROUGH HETEROSEXUAL CONTACT

APPENDIX C**Trainer Text: HIV/AIDS Prevention 101****Topic: Educating Women to Reduce the Risk of Getting HIV/AIDS through
Heterosexual Contact**

Trainer's Guide—page 2
Trainer Overheads—page 15
Participant Handouts—page 33
Trainer Resources—page 45

Trainer Note

In the beginning of the HIV/AIDS epidemic, few women were diagnosed with HIV/AIDS. However, today the HIV/AIDS epidemic represents a growing and persistent health threat to women in America, especially among women of color. In 2001, HIV infection was the leading cause of death for African American women aged 25-34 years, as well as for Hispanic women aged 35-44 years. In the same year, HIV was the 6th leading cause of death among all women aged 25-34 years. While African American women make up only 15% of the total population of women in the U.S., they make up 68% of all new HIV/AIDS cases. Heterosexual contact was the source of 80% of HIV infections among all women in the U.S. in 2003.

As the trainer, you can use your own experience, teaching techniques, and knowledge during this session to expand on certain points if needed. It is important during this session to keep in mind the different cultural backgrounds of the audience. While the target audience is primarily African American, all women are at risk for HIV/AIDS regardless of race/ethnicity and age.

Trainer Text: HIV/AIDS Prevention 101**Topic: Educating Women to Reduce the Risk of Getting HIV/AIDS through
Heterosexual Contact**

Session Purpose: The purpose of this session is to educate women about the risks of HIV/AIDS and the growing number of new HIV infections among women through heterosexual contact. This session should get women to acknowledge their own behaviors that put them at risk for HIV/AIDS. Ultimately the session should give women the skills and knowledge to make informed behavioral changes, to practice safer sex, and to inspire participants to get an HIV/AIDS test.

Length of Session: 75 minutes

Session Objectives:

- I. Participants will understand the scope of new HIV/AIDS diagnoses among women in America through heterosexual sex.
- II. Participants will determine the extent to which they're at risk for HIV/AIDS.
- III. Participants will learn how to reduce the risk for HIV/AIDS.
- IV. Participants will learn about HIV/AIDS testing as a preventive measure.

Session Materials:

- Evaluation survey packets (there should be a pre-test survey (Trainer Resource #1, page 46) and post-test survey (Trainer Resource #2, page 49) in an envelope for each participant)
- HIV Prevention 101 Curriculum Group Evaluation Form (Trainer Resource #3, page 53)
- Group Outreach Contact Form (Trainer Resource #4, page 54)
- Pens (for surveys)
- Large envelope (for completed surveys)
- Participant handouts
- Easel/Pad
- Markers
- Tape
- Overheads
- Overhead projector and screen or PowerPoint Presentation of Overheads
- Male and female condoms to distribute

I. Workshop Introduction & Pre-Test Survey (10 minutes)

- A. Trainer welcomes participants and introduces self, his/her role in the Brothers to Brothers/Sisters to Sisters (BB/SS) project, and the purpose of the workshop (to provide information about risk behaviors, prevention methods, and HIV testing).
- B. Trainer administers the pre-test survey to all participants. (If necessary the trainer reads questions and response sets aloud, and provides clarification when needed.)

- C. Trainer gives overview of workshop agenda (Trainer Overhead #1–“Workshop Agenda”).
- D. Trainer reviews the four workshop objectives and states that by the end of the session participants will:
 - 1. Know more about HIV/AIDS and its impact on women.
 - 2. Know what behaviors put them at risk for getting HIV/AIDS.
 - 3. Know how to protect themselves from HIV/AIDS.
 - 4. Know why HIV testing is important and where to get tested.

II. Introduction to HIV/AIDS: What is HIV/AIDS & How Does It Impact Women? (20 minutes)

- A. Trainer introduces the topic: Educating yourself about HIV is an easy and effective way to protect you against the virus. The first session of the workshop will give you some basic information about HIV and how it affects our community.
- B. Trainer begins lecture: **What are HIV and AIDS?** (Use Trainer Overhead #2/Participant Handout A – “What Are HIV and AIDS?”). Trainer paraphrases each bullet on the overhead, providing information on: 1) how HIV is transmitted; 2) how HIV attacks the body; and 3) the relationship between the HIV virus and AIDS. Trainer answers any questions that arise during this brief overview.
- C. Trainer continues lecture: **How HIV Impacts Women in the World and Locally.** Trainer continues the mini-lecture by stating that HIV/AIDS is not only a global problem among women, but also a local problem. Trainer briefly summarizes the impact of HIV among women across the world, in the United States, within Ohio, and in Dayton by using Trainer Overhead #3.
 - 1. **Women in the World:**
 - By the end of 2003, there were 19.2 million **women** living with HIV/AIDS.
 - Women living with HIV/AIDS account for 50% of the 40 million adults (male & female) worldwide living with HIV/AIDS.
 - Worldwide, more than 90% of all HIV infections (male & female) have resulted from heterosexual sex.
 - In 2002, 5 million people (male & female) were newly infected with HIV.

- In 2002, 3.1 million adults (male & female) and children died of HIV/AIDS.

2. **In the U.S.:**

- There are 990,000 people (male & female) living with HIV/AIDS in the U.S.
- There are 260,000 **women** in the U.S. living with HIV/AIDS.
- 44,000 Americans (male & female) became infected with HIV in 2004.
- African American and Hispanic women represent 25% of all U.S. women but account for more than 82% of AIDS cases in women.

3. **In Ohio:**

- In 2004, there were 14,923 people living with HIV/AIDS, 11,941 were male and **2,980 were female**.
- In 2004, of the 2,980 females living with HIV/AIDS, 1,007 were white, 1,652 were African American, and 215 were Hispanic.
- In 2004, there were 966 new HIV diagnoses. 754 were male and **212 were female**.
- In 2004, of the 2,980 females living with HIV/AIDS, 393 were infected by injection drug use and **1058 were infected through heterosexual sex**.

4. **In Dayton, Ohio:**

- There are 933 persons (male & female) living with HIV/AIDS in Dayton; **19% are women** & 81% are male.
- 41% of HIV exposures among women in Dayton are a result of heterosexual sex.

Continue using Trainer Overhead #3–“How HIV Impacts Our Community” to describe how HIV affects people in Dayton, Ohio.

At the end of trainer’s review, trainer uses the following process questions:

1. What piece of information stood out for you?

2. How does this information affect you?

- D. Trainer continues the lecture using Trainer Overhead #4/Participant Handout B–“Risk Factors & Barriers to Prevention for Women” to talk about how women are at risk for HIV/AIDS by discussing each bulleted point.

III. Reducing the Risk of Getting HIV/AIDS–Risk Assessment Questionnaire & Large Group Brainstorm (25 minutes)

- A. Trainer states that knowing what behaviors put you at risk for contracting HIV are critical if you’re going to reduce your risk of getting the virus.
- B. Trainer asks participants to pull out their “Risk Assessment Questionnaire” handout (Trainer Overhead #5/Participant Handout C). Trainer explains that he/she will read each question out loud and after hearing each question participants should check-off “Yes” or “No”. Trainer reminds participants they will not turn in this questionnaire.
- C. After the trainer has read through all the questions, he/she asks participants to count up the number of “Yes” responses on their questionnaire and to record this number in the upper-right corner of their pre-test survey. Remind participants that the information they completed in the pre-test survey is anonymous, which means it cannot be linked back to them (their name is not connected with their answers). Trainer notes that any single “Yes” answer has put the participant at risk for HIV/AIDS.
- D. Trainer states that knowing the behaviors that put you at risk for HIV is the first step in figuring out what you can do to protect yourself.
- E. Trainer leads a group brainstorm around HIV prevention strategies. Trainer asks the group to list different ways to protect themselves from HIV and records the information on a flip-chart.
- F. Trainer uses Trainer Overhead #6/Participant Handout D– “Reducing the Risk for HIV/AIDS” to reinforce the prevention strategies mentioned in the brainstorm and to fill in any gaps. Trainer emphasizes that the best ways to avoid HIV are: 1) to avoid oral, anal, and vaginal sex; 2) to stop injecting drugs
 1. Trainer states that if you continue to have vaginal, oral, or anal sex you should use condoms and other barrier devices (dental dams) every time you have sex. Trainer also emphasizes that you should never have sex when you are high on drugs or alcohol.

2. Trainer states that if you continue to inject drugs, you should always use sterile supplies and never share syringes, cookers, cotton, rinse water, drug solutions, or other drug preparation equipment. When you don't have sterile supplies, you should always clean your supplies with full-strength bleach before injecting.
3. Trainer states that because of the diversity of drug users and their sex partners, no single HIV/AIDS prevention strategy will work effectively for everyone. A comprehensive approach is the most effective strategy for preventing HIV/AIDS.

IV. Should I Get Tested? (20 minutes)

- A. Trainer introduces topic area by stating that for some people taking the HIV test can be a scary decision. Also, determining whether or not one should get tested is a personal choice, since testing has an *upside* and a *downside*. No matter what the choice, it will affect the individual, his/her family and peer group, and also the community-at-large. To establish how the group feels about testing, the trainer conducts a large-group brainstorm about the pros and cons of getting tested for HIV.

1. **Brainstorm #1:** What keeps people from getting tested for HIV in Dayton?

- i. The trainer should probe for personal, interpersonal (family/friend), and community barriers/risks to getting the HIV test and record this information on the flip chart.
- ii. If necessary the trainer can add the following barriers:
 - Personal barriers: perceived low risk, denial of risk, fear of results, fear of discrimination
 - Interpersonal barriers: fear of family/friend's reaction, partner may think I'm unfaithful
 - Community barriers: lack of testing sites, inconvenient testing locations/times for testing, lack of medical care if diagnosed with HIV, no local support system for HIV+ persons

2. **Brainstorm #2:** What makes it important for people to get tested for HIV?

- i. The trainer should probe for personal, interpersonal (family/friend), and community benefits to getting the HIV test and record this information on the flip chart.

- ii. If necessary the trainer can add the following benefits:
 - Personal benefits: can get medical care, which can extend my life, can change my behaviors that may put others at risk for HIV infection
 - Interpersonal benefits: can protect my partner from getting infected, can get support from family/friends
 - Community benefits: can prevent the spread of HIV in Dayton, Ohio
- B. After brainstorming barriers and benefits to getting the HIV test, the trainer asks the group:
 - i. What things can you do to overcome the barriers to getting tested for HIV? (The trainer should choose 2-3 barriers from the brainstorm and list specific strategies for overcoming each barrier on the flip chart.)
- C. Trainer mentions that someone's HIV status can go unnoticed for a long time and that people who test positive for HIV may not necessarily have AIDS. The symptoms of HIV infection can resemble symptoms of common cold or flu viruses, such as fever, headache, fatigue, and rash. Symptoms are never a reliable way to diagnose HIV infection.
- D. Trainer continues by stating that no matter the reasons, taking the HIV test is a good idea for three simple reasons:
 - i. Getting tested for HIV antibodies is the only way to know you've been infected with the virus.
 - ii. Taking the test is a way to make a new-found commitment toward safer practices.
 - iii. Finding out your HIV status early on can extend your life because you have the chance to get medical care.
- E. Trainer reviews Trainer Overhead #7—"Types of HIV/AIDS Testing" and explains the difference between anonymous and confidential testing, and also describes rapid testing.
- F. Trainer alerts participants to Participant Handout E—"HIV Testing Sites in Dayton, Ohio" that lists local HIV/AIDS testing sites. Trainer also mentions that staff is available to facilitate an HIV test appointment.

- G. Trainer encourages participants who have never been tested to get tested for the first time and encourages participants who have been tested to get re-tested periodically.

APPENDIX D

EXPANDED HIV/AIDS CURRICLUM

APPENDIX D

EXPANDED CURRICULUM: Session One

BEFORE THE SESSION THE INSTRUCTOR DOES:

Arrange chairs in a semi-circle

List the “Terms to Know” on Flip Chart

Make copies of handouts

MATERIALS:

Chart paper

Markers

Paper

Writing instruments

Purpose:

To explain to the client how HIV works in the body.

Learning Objectives:

- I. How HIV works in the body
- II. How HIV medication work/types
- III. Improving adherence
- IV. Advocacy
 - Cultural Awareness
 - Advocating for Combination Therapy
 - Strategies for Overcoming Barriers to Optimal Treatment
 - Professional Development Topics
 - How to Talk With Your Physician

I. How HIV Works In the Body

HIV is showing up more often among African American and Hispanic/Latino people than among other people.

- Almost 7 out of every 10 people infected with HIV are either Black or Latinos.
- HIV has been increasing in Black and Latino communities
- Women infected with HIV 6 out of every 10 are Black, and 2 out of 10 are Latino.

How can this be changed? By helping people learn more about:

- HIV prevention.
- How HIV is spread.
- How HIV works in the body.
- How it becomes AIDS.
- How HIV is treated.

HIV is the virus that causes AIDS.

- HIV stands for “Human Immunodeficiency Virus”.
- AIDS stands for “Acquired Immune Deficiency.”
- AIDS is the disease caused by HIV. People with AIDS lose their ability to fight germs that can make them sick.
- HIV Infection—3 to 6 months.
- Few symptoms—3 to 10 years.
- AIDS Disease

HIV slowly damages the immune system. Sooner or later, the body cannot protect itself against HIV. It cannot protect itself from other germs. This is called AIDS.

- HIV infection gets worse over many years.
- AIDS happens years after you first get infected with HIV. Getting treatment at the right time is very important. It can put off the time it takes for HIV to become AIDS.
- The immune system works in your body to fight germs and keep your body healthy.
- T Cells are the “soldiers” of your immune system
- T Cells see germs in your body, and they work with other cells to destroy them.
- T Cells are a kind of white blood cell.
- T Cells help protect the body from germs.

There are two kinds of T cells.

- “Killer” T cells
- “Helper” T cells

The “helper” T Cell orders the “killer” T Cell to kill an infected cell.

The HIV infected cell is itself a “helper” T Cell. It is the very same kind of cell that gives the destroy order.

“Helper” T cells are needed to fight other germs in your body. When HIV infects the “helper” cells, they cannot give destroy orders to the “killer” cells. This is how HIV damages the immune system. “Helper” T cells are also called CD4 cells. “Killer” T cells are also called CTL cells or CD 8 Cells.

HIV infection is like a war of numbers.

- An HIV infected cell makes many, many more viruses just like itself, and it makes them very fast.
- The body’s immune system must act fast. It must make more T cells to try to keep the virus in check

If you have HIV, your body is like a bucket with a hole in it. The water coming into the bucket is the new T cells. The water going out of the hole is the killed T cells. In most people with HIV who are not being treated, killed cells are going out faster than new are coming in.

What happens in most people with HIV who are not treated?

- Killed cells are going out faster than new cells are coming in.
- People with HIV who are not treated may run out of T cell sooner or later.

No two people are the same. If two people have the same amount of virus in their blood, it may not mean the same thing. But the way the viral load numbers go up or down is a good way to know how well a person is doing in fighting HIV.

There are two good ways to show how close a person is to having AIDS.

- How many CD4 “helper cells” are in the blood.
- How many pieces of virus are in a small sample of blood.

The second thing is called “viral load”. Viral load means how much virus there is in the blood.

Viral load stays about the same in the first three (3) to seven (7) years in a person with HIV. But if the number of CD4 “helper cells” goes way down and the viral load goes way up, a person with HIV will be closer to having AIDS.

When a person first has HIV, the viral load will go up to a point and stay at about that point for some time. This is called the viral “set point”. The higher the viral load at the “set point” the shorter the time before the HIV becomes AIDS.

Your body has a way to fight against HIV and other viruses and germs. It is your immune system. The immune system gives you immunity.

- Immunity is your body's way of keeping you well by holding germs and viruses in check. T cells are the fighters in your immune system.
- CD4 cells are what makes the immune system work. When your viral load goes up, more CD4 "helper" T cells are taken over and killed. This means your immunity goes down. Your body is not able to fight off all kinds of germs and viruses. The CD4 cell count is around 800-1200 in a person who is not sick. Over time, HIV kills off these cells. When the CD4 count goes down to around 200 or below, there are not enough CD4 cells to do the work of the immune system. At this point, a person changes from being HIV positive, to having AIDS. The immune system cannot keep HIV in check. It cannot keep other germs from taking hold in the body.

What do we know?

- HIV takes over CD4 blood cells.
- HIV moves from person to person by contact with blood or other body fluids (vaginal fluids, semen including both cum and pre-cum, breast milk and blood).
- CD4 are the T cells that run the immune system.
- An HIV infected cell can make more viruses just like itself.
- The body must try to make new CD4 cells to keep the HIV in check.
- Sooner or later HIV in the body grows faster than the body can make new CD4 cells.
- The body begins to lose its immunity.
- Now the body cannot fight off HIV and other germs.
- Viral load is a very good way to measure the damage to the immune system.
- When viral load goes up a lot and the CD4 goes down a lot, HIV can become AIDS.

If people with HIV understand the meaning of viral load and the way T Cells work, they will be able to understand how they can be helped by different HIV/AIDS treatments.

There are many different ways HIV can be treated. With treatment, HIV can be something you live with, not something you die from.

For the Instructor:

Improving Adherence

Adherence to Treatment and Treatment Basic Planning

This is one of the biggest problems for people who have a long-term illness. And, it is a problem for people with HIV/AIDS. They have to take so many

drugs every day. Many need help to keep them on the plan. Here are questions you can ask:

- You want to know if he/she understands his treatment plan. He/she should be able to tell you what it is. Ask: What is your drug treatment plan? What do you take? When?
- You want to know if he/she is taking the drugs in the right way. Ask: Did you miss any doses yesterday? If so, how many?
- You want to know if he/she has been taking the drugs in the right way over time. Ask: Did you miss any doses last week? How many?
- You want to know if he/she understands why he/she takes the different drugs. Ask: What is happening to make you miss doses?
- You want to know if he/she understands why he/she takes the different drugs. Ask: Can you tell me which drugs you take and how they work?
- You want to know if he/she understands the dangers of missed doses: Ask: What may happen if you keep missing doses?
- You want to know what changes can be made so missing doses will no longer be a problem? Ask: How can I help you stay with your treatment plan?

Questions Every Person With HIV Faces

- Should I begin treatment or not?
- When should I begin treatment?
- Should I stay with the treatment plan?
- What is more important to me, my health, my comfort, or easy treatments?
- My health: I'll stay with the plan because I want to stay healthy.
- My comfort: I don't want to put up with side effects. I'll stop taking the drugs.
- An easy treatment: Don't put more than twelve (12) pills a day in my treatment. I won't take more than twelve (12), no matter what.
- Should I try other things to stay healthy like exercise and better nutrition?
- Where do I put HIV on my list of things going on in my life?

What If They Don't Speak (much) English?

- They will understand more if you:
- Let them see your face and lips as you speak.
- Smile
- Take your time.
- Listen with care.
- Speak more slowly.
- Speak clearly.
- Take care with how you say words.
- Stick to the main points.
- Stress key words.
- Stay away from slang and jargon.
- Use simple sentences and common words.
- Be clear and to the point.
- Say things in more than one way to get the point across.
- Write down key words or points (CAREFUL, they may not be able to read.)
- Say “do not” in place of “don’t”, “cannot” in place of “can’t”. Contractions are hard. Stay away from them.
- When you can, use words he/she has used. These are words you can be sure he/she knows.
- Give the big picture first, before you talk about key points.
- Ask the person to write words you cannot understand. (CAREFUL, they may not be able to write.)
- Act out points you are trying to make.

Other hints:

- Don't ask "Do you understand?" You may get a yes even when they don't. Ask questions that can't be answered with "yes" or "no". (what, when, why)
- Watch for nods and other signs that the person understands.
- Have them say key points back to you.
- Don't use jokes or humor.
- Stay away from sayings like "drive me up the wall" or "kick the bucket". We say so many things that mean nothing to people who don't speak English.
- Having someone who speaks the language may help you communicate better.

You can't be sure that:

- If they can say it, they understand it.
- If they can say it, they can read it.
- If they can say it, they can write it.
- There is a word in their language for every word in English. If what they say doesn't fit in right, use other words to make it clear.
- They can read and write in the language they speak.

APPENDIX E

THE STAGES OF HIV DISEASE

APPENDIX E

The Stages of HIV Disease

HIV Is A Continuum:

Most of us are used to thinking of disease in very simple terms: if you feel sick, you are sick; if you feel healthy, you are healthy. However, because HIV may be causing subtle changes in the immune system long before an infected person feels sick, most doctors have adopted the term “HIV Disease” to cover the entire HIV spectrum, from initial infection to full-blown AIDS (which can also be called “Advanced HIV Disease”).

The continuum that follows and its stages are representative of the experience of many people with HIV. The time that it takes for each individual person to go through these stages is varied. For most people, however, the process of HIV disease is fairly slow, taking several years from infection to the development of severe immunodeficiency.

Infection:

HIV enters the bloodstream and begins to take up residence in the cells. People with HIV are considered to be infectious immediately after infection with the virus. Although some studies suggest that the level of infectivity varies over time depending on the stage of the disease in which the person is, it is not possible for most HIV-infected people to find out what their level of infectivity is.

A person with HIV is infectious at all times. Also, a person does not need to have symptoms of look sick to have HIV. In fact, people may look perfectly healthy for many years despite the fact that they have HIV in their bodies. The only way to find out if a person is infected is by taking and HIV antibody test.

Primary Infection (or Acute Infection)

Primary HIV infection is the first stage of HIV disease, when the virus first establishes itself in the body. Some researchers use the term acute HIV infection to describe the period of time between when a person is first infected with HIV and when antibodies against the virus are produced by the body (usually 6-12 weeks). Within the first 72 hours after exposure, postexposure prevention (PEP) may be possible.

Up to 70 % of people newly infected with HIV will experience some “flu-like” symptoms. These symptoms, which usually last no more than a few days, might include fevers, chills, night sweats and rashes (not cold-like symptoms). The remaining percentage of people either do not experience “acute infection,” or have symptoms so mild that they may not notice them.

Given the general character of the symptoms of acute infection, they can easily have causes other than HIV, such as a flu infection. For example, if you had some risk for HIV

a few days ago and are now experiencing flu-like symptoms, it might be possible that HIV is responsible for the symptoms, but it is also possible that you have some other viral infection.

During acute HIV infection, the virus makes its way to the lymph nodes, a process which is believed to take three to five days. Then HIV actively reproduces and releases new virus particles into the bloodstream. This burst of rapid HIV replication usually last about two months. People at this stage often have a very high HIV “viral load.” However, people with acute HIV infection usually will not test HIV antibody positive, since it takes the body approximately one to three months to produce antibodies against HIV.

Seroconversion:

This term refers to the time when the body begins producing antibodies to the virus. About 95% of the people infected with HIV will develop antibodies within three months after infection. Nearly all people will develop antibodies within six months after infection.

Most people develop antibodies within three months and some can take up to six months. People who get tested need to wait at least three months for the test. If their first result is negative, they should come back for a second test three months later.

Immune System Decline:

The virus appears to slowly damage the immune system for a number of years after infection (perhaps because the body is able to keep it in check during this time). In most people, however, a faster decline of the immune system occurs at some point, and the virus rapidly replicates. This damage can be seen in blood tests, such as lowered T-cell counts, before any actual symptoms are experienced.

People who are HIV–positive should see a doctor to monitor their immune systems. By getting lab indicators (such as the viral load test) and observing how they are changing over time, they can get a better sense of whether HIV has already caused any damage to their immune systems. As mentioned above, a development in the last couple of years in the treatment of HIV disease is what doctors call “Early Intervention” or “Early Care.” The principle behind this concept is that early rather than late medical care may give people better chances of survival and better quality of life. It is extremely important that people with HIV learn that they have to see a doctor even if they feel fine at the moment because the virus could be already damaging their immune systems.

Understanding that **HIV Disease** begins immediately after infection enables us to begin treating infected persons before symptoms appear. This important medical advance has significantly extended the lifespan and the hope of HIV infected people.

Mild, Non-Specific Symptoms:

Once the immune system is damaged, many people will begin to experience some mild symptoms (skin rashes, fatigue, slight weight loss, night sweats, thrush in the mouth, etc). Most, though not all, will experience mild symptoms such as these before developing more serious illnesses. Although one's prognosis varies greatly depending on one's ability to access support, services and preventative treatment, it is generally believed that it takes the average person five to seven years to experience their first mild symptom.

These symptoms are not specific to AIDS. However, they should be of concern to people who have tested positive to HIV. Usually, symptoms occur when the virus has already caused considerable damage to immune system. For that reason, people with HIV should not wait until symptoms appear to get medical treatment. Also, people with high risk for HIV should not wait to get symptoms to take the HIV-antibody test.

If you are a person with HIV experiencing any symptoms, we suggest that you have them checked by a health care worker.

More Severe Symptoms; Opportunistic Infections and Diseases:

When immune system damage is more severe, people may experience opportunistic infections (called "opportunistic" because they are caused by organisms which cannot induce disease in people with normal immune systems, but take the "opportunity" to flourish in people with HIV). Most of these more severe infections, diseases and symptoms fall under the Centers for Disease Control's definition of full-blown "AIDS." In a San Francisco study of gay men, the median time to receive an AIDS Diagnosis among HIV-infected men is 10-11 years. (Again, this statistic predates the advent of more powerful anti-HIV drugs.)

Receiving an AIDS diagnosis does not necessarily mean that the person will die soon. Some people have lived many years after their diagnosis. However, it is extremely important that people in this stage of HIV disease get adequate care for any symptoms or conditions that develop.

People with an AIDS diagnosis have coined the term "living with AIDS" to describe their experience. We prefer this term over others because it implies empowerment which may be crucial in maintaining a positive frame of mind and possibly even in surviving longer. As the term "HIV-disease" becomes more common, many people are also using the term "living with HIV" to refer to anyone who has the virus.

Does everyone who has HIV eventually get sick? Nobody knows.

Many researchers believe that, in some small percentage of people with HIV, the immune system may be able to defeat the virus. As existing treatments are used earlier in the course of HIV disease and new treatments are developed, these, too will postpone, and possibly prevent, illness. Unfortunately, however, studies show that the majority of untreated people do eventually become ill from HIV. Some long-term survivors may do so well because of their unique body chemistry, or access to a combination of medical,

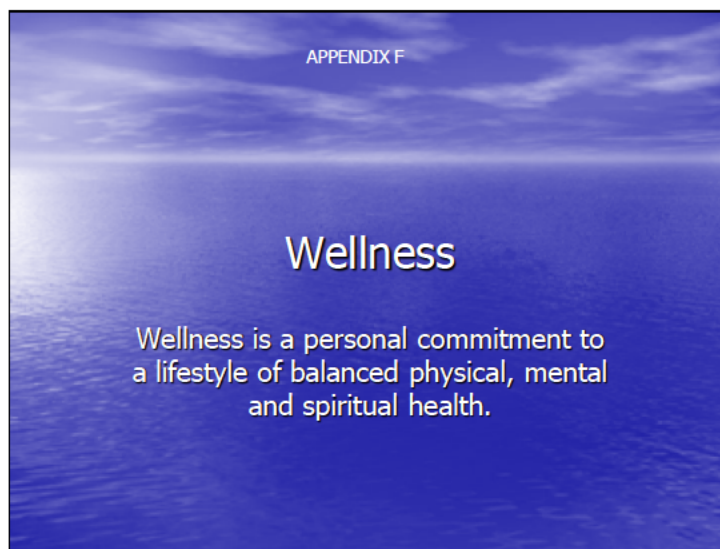
emotional and spiritual support, or something yet unknown to us. Others may find their health declining even with access to all of these things. We don't really know the answer yet, although you can be sure scientists and researcher are searching for the common thread that links long-term survivors together.

APPENDIX F

WELLNESS CURRICULUM USED TO TEACH CHURCH MEMBERS ABOUT ESTABLISHING WELLNESS MINISTRIES

APPENDIX F

Slide 1



Slide 2

What is a Wellness Program?

- A wellness program is concerned with planning programs that helps people avoid disease and to help individuals improve their physical, mental and social well-being.
- Wellness programs are oriented toward maximizing the potential of which the individual is capable.

Slide 3

Why is a Church an ideal Setting?

- Churches serve a a center point for communities
- Churches are great channels to disseminate health information and offer health screenings
- Many of our values, attitudes and beliefs are formed at church
- Churches offer a clearly defined and accessible audience
- Churches offer access to populations that are of high priority: Families, minorities, senior adults and women
- Church programs include a spiritual connection that is needed in all healing processes

Slide 4

Steps to Starting a Wellness Program

- Assemble a group of 6-12 church members, who have an interest in the relationship of health religion, to plan and execute the wellness activities
- Members do not need to be in the health field to join, but it is ideal to try and recruit nurses, physicians, social workers, health educators and school teachers

Slide 5

Committee Work Areas

- Sponsor health-related activities in already existing church programs (ex: Sunday School)
- Sponsor new programs (ex: health fairs)
- Create ways to support healthy behavior and turn unhealthy behavior around (ex: healthy soul food pot-luck)

Slide 6

Committee Members Should:

1. Believe that certain lifestyles can negatively / positively impact one's health
2. Be familiar with congregational policies and procedures
3. Be committed to goals and procedures of the wellness committee
4. Have some authority, influence or trust among the members of the congregation
5. Encourage others to participate in wellness activities
6. Attend meeting regularly to assist the planning, implementing and evaluation of the wellness program

Slide 7

Committee Members Must

Gain the support of the pastor or church leader. Chances are your program will not be successful without the support of these key people.

Slide 8

Committee Members Must

Survey the congregation to determine their interest and perceived needs

Surveys can be passed out in a bulletin or mailed to their homes and returned to a special box

* Always set deadline for surveys to be turned in

Slide 9

Committee Members Must

- Determine the congregations needs & interest. This can be accomplished by using the surveys or brainstorming with the wellness team

Slide 10

Remember

- Choose dates and times for events and begin planning. You may want to offer health related programs weekly, monthly, bi-monthly or on a quarterly basis

Slide 11

What to do?

- * Make health related brochures available
- * Create fliers announcing free exercise classes
- * Book a speaker to discuss a health topic of interest
- * Provide blood pressures / blood sugar checks every Sunday
- * Plan a health fair, inviting several agencies & screenings
- * Plan a healthy lunch / dinner day (invite a nutritionist in prior to the event)
- * Team up with a fitness instructor and start a walking program

Slide 12

Evaluation

Evaluate your program as you go along. This will help determine the congregations likes, dislikes and future needs.

- Short interview with participants: by phone or in person
- Give evaluation forms out after each event for participants to fill-in, or simply take attendance at various functions

Slide 13

Before the Actual Event Considerations:

Financial budget

Who will fund the event?

Food, paper, health screenings
entertainment, door prizes, decorating and
thank you notes for speakers and/or
volunteers

Slide 14

-Continued

Community Resources

- To provide literature, speakers and health screenings at no cost
- They should be contacted well in advance to insure proper scheduling
- Don't forget to thank them for the services rendered

Slide 15

Location

Where will the event be held?

Consider size, accessibility, safety, physical lay-out, opportunity for privacy, quietness, availability of equipment and support personnel

Slide 16

Personnel

Who in the church can volunteer to help with event?

- Staff should be sensitive to participants
- Ability to work with a team
- Friendly, compassionate & respectful
- Children can help pass things out and clean up.

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